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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

In Answer to Some Questions

OUR OCTOBER editorial which described the current status of the Interim Classification of Schools of Nursing Offering Basic Programs (1949) asked nurses to be sure they understand what the Interim Classification is and its significance. It is evident now that before they can accept the Classification wholeheartedly and interpret it with understanding and objectivity nurses want to know more. They have raised questions which show in many instances considerable thought and in other instances considerable fear. Here, as always, fear can be dissipated by knowledge.

Marion Sheahan, director of programs of the National Committee for the Improvement of Nursing Services, has been in close contact with the questions raised. She tells us that confusion exists about the future status of the registered graduate nurse of today; that concern is expressed that the control of the nursing profession will slip from the profession itself to the Federal Government; and solicitude is shown that the hospital school of nursing may be eliminated.

It is readily seen that these queries are not superficial doubts thrown out to be stumbling blocks. They stem from great uncertainty and deserve the serious consideration given them by the members and staff of the National Committee for the Improvement of Nursing Services, as well as all the national professional organizations.

The questions cropping up at this time are similar to the types of questions asked when *Nursing for the Future* was published. A first point for clarification is that Dr. Brown's report, in which she expresses points of view and recommendations for which she alone as an individual is responsible, has not been adopted formally by any national or state nursing organization. It is readily conceded that professional nursing organizations find and will continue to find valuable leads for study and action in the Brown report, but it is vital now that nurses do not confuse the recommendations of this report with the programs and policies of any national organization, including the NOPHN. The NOPHN has been stimulated by Dr. Brown's ideas and has discussed them at board meetings and committee sessions. Her clearcut analysis has affected our thinking in many ways, as it must the thinking of all those who are sincerely interested in the quality of all nursing service.

Let us return to the specific questions.

Every graduate registered nurse has proved that she has at some time met the requirements for registration of the nurse practice act in the state or states in which she holds such registration. So long as she keeps her registration status current the nurse is protected as to her standing as a graduate registered nurse by the same nurse practice act. Regardless of what criteria may be set in the future concerning qualifications for nurse registration these cannot affect the status of nurses previously registered, as changes in the law will not be retroactive. There is no rescinding of a nurse's registration except where a nurse herself commits infringements against the law and these must be proven through legal proceedings.

There never has been a period in which professional organizations and nurses through membership in their organizations have been so aware of their responsibility for the direction in which nursing is to go. There never has been a time in which so many American nurses have earnestly concerned themselves

with the control of their profession so that nursing may continue to make an increasing contribution to the health and welfare of our own country, of the whole world in which all people are ever drawing closer. Many nurses believe their profession can best grow and their service best answer needs when they can sit down with other interested citizens in planning and coordinating nursing education and service with other aspects of community education and services. This in no way means that the profession assumes any less responsibility for the personal and professional welfare of its practitioners.

Some have stated that if nursing receives federal aid for professional education, nursing will shortly find control of professional activities slipping away from it. This presupposes that the national nursing organizations have been functioning in isolation. Anyone who has ever visited a national office is more apt to think she is in the middle of nursing's Main Street. Early in 1949 the Committee to Study Federal Legislation of the NLNE—in which the five other national nursing organizations are represented—outlined, among others, these principles to govern federal aid to nursing education: (1) Federal aid must not bring direct federal control of any nursing education program—funds are to be administered by the individual institution. (2) The federal role is secondary to that of aid from private and state sources.

At this writing, the Emergency Professional Health Training Act of 1949 has been passed by the Senate and sent to the House of Representatives where it is now under committee consideration. There is no doubt that those who advocate its passage have at heart the health needs of the country for more and better trained health personnel. This bill would provide grants to schools and scholarships for education in the fields of public health and nursing as well as medicine, osteopathy, and dentistry. A careful study of its contents fails to disclose any threat, expressed or implied, of control of any of the categories of professional education by the Government. The choice as to whether or not governmental aid, when available, will be accepted would be a voluntary one.

The hospital school of nursing, like many other old and established social institutions, may be the better for marching along with the changing times. Educational philosophy and administration have made marked advances in this century. This is especially true of education for the professions. The hospital school of nursing which since its inception has undergone many changes undoubtedly will continue to change in light of current trends. As it does so it will continue to serve both nursing and community needs in many areas.

During the last 25 years there has been a slow growth of the collegiate basic professional schools of nursing. Many of these have evolved out of hospital schools. The social and educational environment in which we live encourages a greater use of the combined facilities of institutions of higher learning and of hospital and health services for the education of nurses. It is expected that hospital schools will plan to use more collegiate resources and that concurrently more collegiate schools of nursing will be developed also.

The Interim Classification is a list of basic schools of nursing showing the ratings of the schools when compared with each other on the bases of self-reported practices as of February 1949. The list in itself is not a perfect instrument and will wield no magic influence. It is an interim step necessary if the profession of nursing is to continue to study, evaluate, and plan for its own progress and the high quality of service the American people have come to expect from our profession. Nurses themselves must believe this and must be prepared to explain it. The autumn issues of all the professional nursing magazines have carried factual data on the Interim Classification. Nurses are faced with a real responsibility to inform themselves on this subject.

THE INTEGRATED CURRICULUM

A Pattern in Basic Nursing Education

LAURA E. ROSNAGLE, R.N.

THE INTEGRATION idea is spoken of as one of the new patterns of education. Actually it is giving "old themes new forms and new meanings." Its application to education is relatively new and began in the early 1920s. It may be said that integration is a pattern by which education seeks to link theory and reality.

We are all aware of the sensitivity of educational patterns and processes to the smallest changes in the social, economic, and political influences of the time. In Cincinnati we see the integrated program pattern as representing the most forward evolutionary challenge in nursing education. The program has evolved by reason of the impelling forces or pressures which are a part of the times in which we find ourselves today.

We believe that the integrated curriculum pattern represents the way in which unity, continuity, and sequence of content can be arranged for best use and economy of the learner in order to meet the needs, desires, hopes, and goals in the nurse's ongoing life as well as meeting its present challenges. If we accept the educational component that education tends to develop certain types of behavior, certain kinds of attitudes, as well as technics, which are essentially a result of the sociological properties of the group in which the education occurs, the environmental atmosphere in our schools is of unmistakable importance. Essentially, we are preparing students for group participation—small and large, sometimes one, sometimes the other, in the family, in the hospital, and in the community. Curriculum content must therefore be selected to meet the social and cultural implications as well as the technical responsibilities of a concrete, dynamic whole of the student's life problems and life purposes as they are faced today. Hence the obligation for nurse leaders and faculties of schools to be sensitive to the present needs and have a perspective of the future in so far as that is humanly possible. They must remember that the socio-psychological situation is a dynamic whole and that change in one of its parts implies change of the other parts also. Flexibility therefore must be a certain characteristic of any good curriculum pattern.

This pattern recognizes barriers and group restraints but the socio-psychological implications of the theory are a dynamic challenging progressive force. The pattern promotes the practice of democratic principles by participation in democratic processes which Dewey said "must needs be continually practiced and improved in each generation." The group dynamic method of discussion takes this one step further in that the technic permits the arrival at democratic decisions. Discussion by the group dynamic method permits wider understanding and practice as a way of developing democratic leadership and arriving at democratic conclusions.

We attempt to arrange content material into

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levels of learning according to the background of the student. Judgment, understanding, perception are impossible without a related background and the meaning of every event depends directly upon the nature of its background. Whatever a person does or wishes to do he must have some "ground to stand upon." The firmness and clearness of his decisions depend largely upon the stability of this ground. The social group is one of the most important constituents of background, since during most of adult life each person acts not as an individual but as a group member or a group leader.

Let us move on to the applications of the factors to nursing education. How can the integration concept be applied to the curriculum pattern in a school of nursing? Far be it from me to say it is the best method or the only method to produce a nurse today but I will say it is consistent with the philosophy of our times and with our needs.

Much more study must be done by all nurse educators on the underlying principles of this philosophy and their implications to nursing education. By no means do we have all the answers but if we have any of them we are glad to share them.

It was said previously that the recognized pattern of integration has been an evolving one. If one looks at a cross section of nursing schools in this country, it is possible to see all types and variations of past patterns existing today. Only as each school is able to increase "freedom of movement" within itself does its development expand. There are many types of barriers which have kept schools of nursing within rather narrow fields of influence, such as economic, authoritarian, political, religious.

ORGANIZATION FOR INTEGRATION

1. *Administrative.* Organization alone does not produce integration, but integration in organization defines the freedom of action and the atmosphere for the group. It seems quite apparent that autonomy of a school of nursing provides more freedom for development within the nurse group. Autonomy as a college in a university, also offers to nurses the support of higher education in raising its levels of admission, of teaching, and of measuring its product in relation to broader citizenship responsibilities. At the University of Cincinnati, the College of Nursing and Health is one of twelve autonomous colleges. The dean has equal status with the deans of the other colleges, and the faculty are granted equal recognition with other faculty. Members of the faculty function on committees of the university as a whole, such as admissions, university senate, executive faculty, health, and others. There must be lines of authority established and respected in any organization to facilitate locomotion toward an aim, but the greatest possible freedom to faculty members must be given consistent with the time perspective in reaching the aim of the school. This can best be done by integrative group functioning. We do not subscribe to the organization of parallel lines of authority, such as classroom faculty versus ward faculty, or clinical instructors versus head nurses and supervisors. Each faculty member assumes some obligation in each area. Some have greater classroom responsibilities. Some have greater clinical responsibilities. But there is integration and interpenetration and interweaving of functioning in such a way that the student is not placed between two groups, being guided one way by one group and another way by another group. This requires faculty members oriented to the responsibilities, content, and organization of the total plan as well as of their own fields in order that each may see her place in relation to the whole organization. This may be accomplished through the proper faculty organization and the active participation of each member in it.

2. *Organization of faculty.* The faculty is organized into (1) groups with like interests and (2) committees of mixed membership. All functions are carried out as a result of group planning and group decision.

There are several psychological factors of which this plan of organization takes account. Perhaps the most basic factor is that the unity of sociologic wholes can be defined by the interdependence of its parts. Directly related to this factor are the following de-

sirable consequences of this type of organization:

1. Information concerning all matters is disseminated to all groups.

2. An in-service program in keeping with the needs of the group as determined by them may be carried out more satisfactorily.

3. Group planning and group decision are considered more than the sum total of each individual's contribution.

4. Added zest is given to carrying out plans in which each has had a part in formulating.

5. The properties of the social group (goals, stability, organization) are something different from those of the individuals in the group. Hence some common agreement must be arrived at to put plans into practice efficiently.

3. *Organization of students.* The student organization is carried on in much the same way. This serves to give students practice in group action as well as promoting democratic relationships. A student-faculty committee to solve common problems is satisfactory and helpful. It is at the same time informative and morale building. There are other committees on which both faculty and students serve. However these are not the so-called faculty committees.

AIMS AND OBJECTIVES

It is the aim of the College of Nursing and Health to graduate professional nurses who have the ability to give skillful, sympathetic, and intelligent nursing care in any patient-nurse situation. The college's objectives are: (1) to select carefully those young women who possess the innate qualities and acquired knowledge that are prerequisite to the preparation of a professional nurse (2) to offer a well organized integrated and carefully guided program of scientific, social, and professional instruction and experience which will develop expertness in nursing care in the home, hospital, or community and (3) to stimulate a desire for personal growth and professional development as well as a feeling of responsibility for professional progress.

INTEGRATION IN COURSE CONTENT

Integration in the area of course content needs the most careful scrutiny and consistent effort. Flexibility in method, arrangement, and actual subject matter must allow for the introduction of new ideas, new findings of research related to treatments, medications, and nursing measures.

The selection of content material is made by those instructors who teach the classes and who are expert in each field included in the course. The associate in charge of the basic program coordinates this material. This is done through (1) conferences with physicians and non-nurse personnel and (2) through meetings with the nurse instructors' group. In the instructor's group evaluation of content in relation to the aims and objectives is made, lessons are arranged within the course to provide for integration of learning, and the sequence of units are spaced to provide background for clinical experience.

The overall planning is done by the Committee on Curriculum which is composed of the associates in charge of the basic program and of nursing service together with the heads of the various departments, such as, biological and physical sciences, social science, nursing arts, and each clinical area. This committee decides such matters in relation to the various courses as sequence, placement, length, and screening to prevent repetition in teaching.

INTEGRATION IN THE APPLICATION OF THEORY TO PRACTICE

Within her environment the student finds her problems and her solutions. As she does this her own personality is developed. The most important function of the educational pattern is to aid the individual student in achieving integration within herself, within her environment. This is accomplished through group activity which weaves into the desired learning outcomes those understandings, attitudes, and technics in order that they may become a part of the individual student's personality.

Nursing has always had the distinct advantage of real situations in which to learn as compared with the posed or artificial situations provided by other fields. But it is essential to structure the surroundings of those learning situations in which she faces real nursing problems and to help her organize

both her academic and practice experiences to deal satisfactorily with the problems at hand. It is extremely important then that the teaching obligations of those who guide the students' learning in the clinical areas be integrated so that no gap occurs between the classroom and the bedside. Furthermore, it becomes increasingly important that the preparation in theory and practice of head nurses and supervisors be equal to that of members of the faculty who give the major portion of their time to instruction in the classroom, but let it be emphasized that the contribution of the least well prepared faculty member not be underestimated. At this place in the student's educational plan, it is especially imperative that there be no separation of faculty into teaching and service but instead that complete interweaving of functioning take place if the student is to achieve integration of understanding, attitudes, and technics.

To put into practice any plan, those who use it must understand and feel secure in using the tools. Otherwise it is on paper only.

The thinking of the faculty in these two major areas is brought together by the Committee on Integration in the Application of Course Content. This is a rather large committee of head nurses, supervisors, instructors in foundation courses, associate directors, and the dean. It is fluid in that those members giving the major portion of their time to ward administration are present only when the area of their interest is under discussion.

This committee through group discussion considers the learning situations related to the needs of students. It selects from all courses those items which are related to each specific teaching situation and tabulates them so that they may be again brought to the student as her learning is guided in a real situation. This entails recall and reorganization of these items on the basis of the needs of the individual patient as a person. The selection and structuring of the situation in the clinical environment are usually done by the head nurse or supervisor but the teaching may be done by any one of the members of the Committee on Integration in the Application of Course Content. All are informed and each is vitally interested in knowing that her particular responsibility in accomplishing the aim and objectives of the organization is effected between the student and the patient. Unless all faculty members who teach in a school can see that each student knows and can give good patient care, the measure of her ability and effectiveness as a teacher cannot be determined. At the same time through direct patient contact course content is kept alive and up to date.

The Committee on Ward Teaching determines the method to be used, the content of the various levels of experience, and the specific arrangements for planned clinical instruction. Careful consideration is given to the facts that knowledge of the past leads to an understanding of the present, that tasks to be learned must be real to the learner, and that there are restricted regions of difficulty within which success and failure are possible. Realistic goals must be those set near to that which the individual is able to do or to his "level of aspiration." To make use of this factor in teaching nursing care, content is analyzed as a whole and divided into areas of relative difficulty. Assignments are made according to the student's knowledge at a given time and opportunity for progression in experience is provided in the clinical situation. Students are assigned to the basic medical and surgical services each year for a given amount of time with duties of increasing difficulty. By the better arrangement of problems the number of repetitions required to learn is lessened. Repetition then becomes a matter of individual differences.

It has been previously stated that we do not subscribe to two parallel groups, one functioning in the classroom and one in the clinical division. Our personnel interweave and interlace their teaching duties. Both groups attend some lectures and give others, and both groups teach at the bedside.

INTEGRATION IN ROTATION AND ASSIGNMENT PLANS

The assistant in nursing service as a member of each of the previously mentioned committees and working with the associate in charge of the basic program assigns students to various departments for experience in

respect to their previously structured knowledge. A copy of the individual student's program for four years is made when she enters the school. Unless illness or other emergency events occur, the student may know her assignment in point of location and time soon after her admission to the school.

INTEGRATION IN TESTING, MEASURING AND RECORDING

An experience record is kept by the student and carried with her throughout a particular service. The summary is made by the supervisor.

Final comprehensive written and oral tests are given at the end of each service. They are not the ultimate measures of the knowledge and abilities which the student has obtained but they help to keep both theory and reality within the vision of the teacher and the learner.

It is our hope that through this discussion it becomes evident that integration is a "whole" plan not just the organization, or a course, or a faculty committee, or a ward teaching plan. It must not be so lightly misinterpreted or misconstrued. To capture the true understanding of integration the study of its origin and development must be much deeper than the vocal repetition or pencil copying of the word. We recommend it to schools of nursing for deeper understanding and further experimentation. It is a challenging, consistent, and democratic educational plan with tremendous possibilities for development. It is in a sense a philosophy of education with its own methods of attainment.

This article is based on a paper given at the annual meeting of the Association of Collegiate Schools of Nursing in Cleveland, April 30, 1949.

BIRTHDAY CELEBRATION—TEACHERS COLLEGE

The Division of Nursing Education at Teachers College, Columbia University, chose as the theme for its fiftieth birthday celebration "The Future of Nursing Education." A birthday affords an opportunity to look backward and Teachers College may well be proud of its contributions to the international field of nursing. But it is the future that is always exciting.

During the October 12-14 observance there were a series of meetings, special conferences, a gala dinner, and a luncheon. The papers will be published in the Proceedings and available soon. One topic of special interest to all nurses is the changing curriculum. Mrs. Louise McManus, director of the Division of Nursing Education, at the luncheon meeting gave a preview of the contemplated curriculum. Believing that curriculum development must be a continuing process and a cooperative development, the college made arrangements for all the faculty members to share in the study which has been underway during the last three years under the chairmanship of Mary C. Connor. The student body also were brought into the review and planning activities. The proposed revisions are a synthesis rather than a compilation of courses. Some old familiar courses have outlived their uses and will be dropped; others will be added. The present 10 major areas in nursing will be retired in favor of proposed four new ones: (1) administration and guidance (2) supervision (3) curriculum development and instruction and (4) professional practice and specialized fields. Several experimental courses have been set up. These are in the nature of core courses, such as foundations of nursing, tradition, history, international aspects, and so on, which every nurse regardless of her field should know.

Mrs. McManus' report which of course covered many high spots in nursing education made her listeners eager to see the completed curriculum study. She commented that the study committee has also been interested in defining what responsibilities a university has to the community outside its doors.

IN-SERVICE TRAINING IN MENTAL HYGIENE

SIBYL MANDELL, PH.D.

THE DIVISION of Mental Hygiene in the Baltimore City Health Department was created some two years ago as part of the Bureau of Child Hygiene. Our responsibility has been to foster the health of the whole child up to school age, with the emphasis placed on emotional health since this was an aspect of the work which had not previously been stressed. The program has been essentially an educational one of in-service training for public health nurses carried on by the division chief. The actual participation of the mental hygiene consultant in the work of the well baby clinics has only recently become part of the program. We have confined ourselves largely to the nurse education program described below and a few orientation meetings for the physicians staffing the well baby clinics. We have also held meetings to which all nurses and physicians were invited at which the division chief presented certain aspects of mental hygiene which were illustrated by such motion pictures as "Life With Baby"[1] and "Life History of Mary."[2]

Public health nursing in the Baltimore City Health Department is a generalized program of which maternal and child health is only a part. It includes such varied aspects of public health as tuberculosis, venereal and other communicable diseases. The nurses work in well baby and other clinics, in schools and in homes.

There are, at present, some 180 nurses and supervisors in the department. We felt we would derive more benefit from the program if the nurses were divided into small discussion groups rather than brought together in large numbers for a series of lectures. With this in mind, the division chief prepared a booklet entitled, "Outline of Mental Hygiene in Maternal and Preschool Child Health For Public Health Nurses",[3] the text of which was to serve both as a syllabus for the classes and as an aid to the nurse in using mental hygiene as a component part of her work, especially in the field of maternal and child health.

After some experimental procedure, the following administrative plans were adopted. The division chief, functioning as group leader, focused her attention on one or more health districts at a time according to their size. The nurses of the city were divided into 18 groups, each group consisting of approximately 10 nurses. One group consists of recently

[1]Gesell, Arnold. Life With Baby. Yale Clinic of Child Development film.

[2]Fries, Margaret. A Psychoneurosis With Compulsive Trends in the Making: Life History of Mary from Birth to Seven Years. New York University Film Library.

Dr. Mandell is chief of the Division of Mental Hygiene in the Bureau of Child Hygiene, Baltimore City Health Department.

[3]Baltimore City Health Department. Preventive mental hygiene is started in the well baby clinics. *Baltimore Health News*, Vol. 25, January-February 1948.

appointed nurses. As an introduction to their seminars the nurses attend two hours of lectures by a psychiatrically oriented pediatrician on the staff of the Bureau of Child Hygiene. Each group has 10 weekly 1½-hour seminars, known as "basic seminars" and thereafter each group meets at monthly intervals for "follow-up seminars." In addition the mental hygienist accompanies each nurse, at least once, on her routine home visits. She is also available for consultation or to go on particular home visits at the request of any nurse who thinks that such a procedure might prove helpful in meeting a given situation. The program is so arranged that, after the group leader has met with nurses in all the city health districts, she will continue with them indefinitely at monthly intervals. In addition she will be holding a series of 10 basic seminars, probably twice yearly, with such nurses as have recently been assigned to the department.

Discussion and dramatic technics predominate in the seminars. The lecture method is seldom used. However, there is an attempt to direct the discussion so that the important points in the outline are touched upon in somewhat logical, if not always chronological order. It is obvious, of course, that matter discussed under such a heading as "Suggestions for Interviewing" will premeate all discussions dealing with the presentation of such matter, as will such basic considerations as the fundamental nature of the first years of life in forming personality and the importance of the nurse's own feelings and attitudes. After about the first three sessions, discussion usually becomes freer, as the permissive attitude of the group leader is recognized. By this time some members of the group are able to release a certain amount of aggression and some anxiety has been relieved either by personal contact with the leader during the home visiting period, during a consultation period, or in other ways. At this point we introduce dramatic technics.

IN THE FIRST reconstruction of a situation it has been found advisable for the leader to take the part of a nurse who is new to our health department. It is recognized by the group that the leader in playing this role will probably use some undesirable technics in interviewing. In this first small drama a nurse usually plays the role of an expectant mother. This gives the group an opportunity to commend the nurse who plays the mother for the realistic material presented, since most public health nurses have had considerable experience in such situations. It also enables the group members to criticize the leader, who is playing the role of the nurse, destructively as well as constructively without, it seems to them, attacking her personally since presumably she is fully aware of the error of some of her ways. For example, the "new" nurse may fail to introduce herself by name, place her bag on the floor, ask a great number of direct questions, and make certain errors in directing the expectant mother to the prenatal clinic. Working in a new district the leader, playing the role of a nurse, sometimes confuses times for clinics and some group member usually catches this mistake. At such a time the group leader may say that she has not made this particular error on purpose and is grateful for having it called to her attention. It has been found that such an attitude tends to reassure most members of the group and paves the road for a discussion of further interviewing technics where there is more or less divergence of opinion.

In the subsequent dramatized situations the leader usually plays the role of the mother, planning them with a view to discussing a certain point. One of the chief means used by the nurse to help the mother to prevent problems from arising is through anticipatory counsel, whereby the nurse gives the mother some idea of what she may expect in the near future and how she may meet such situations as will probably arise. Thus our playlets have dealt quite simply with an expectant mother who is being helped to prepare for nursing her child or, failing this, to hold him in her arms while giving him the bottle. Other dramatized situations may be that of a postpartal visit, where the overly meticulous mother is helped to postpone bowel training or to use some flexibility in reference to feeding time schedules. Another situation deals with the infant who is pulling himself to a

standing position in crib or pen which gives the nurse an opportunity to discuss with the mother arrangements which may have to be made at the time when the child starts running about freely, becomes interested in exploring his world, and reaches out for breakable or dangerous objects. We have acted out the situation of the mother who complains of thumb sucking, the mother who is disturbed because toward the end of the first year of life the child seems to be losing his appetite, the mother who is embarrassed by an older child asking questions about the advent of a baby, the mother who complains of her health when actually she is disturbed by a recent development in her marital relationship. These and many other situations recognizable to home visitors are presented and discussed by the group.

More and more often, to our gratification, the nurses have brought to the group problems encountered in their work. At times the leader, at the nurse's request, has played the role of the nurse while the nurse acted as the mother. Technics used have been discussed, their desirability considered, and the group as a whole has made suggestions for the further handling of the situation. There are times also when we have found it helpful to repeat an episode two or three times with different members of the group acting as the visiting nurse.

Such dramatic treatment has seemed conducive to discussion. Sometimes it adheres rather closely to the particular phase of child development involved and at other times wanders farther afield. The use of certain interviewing technics is frequently brought up as are the feelings of the nurse as well as those of the mother in question. For example, the situation was presented in which a mother had not received adequate anticipatory counsel and showed concern because the infant's appetite was decreasing toward the end of his first year of life. It was the consensus that in this particular case the mother was concerned because she was ignorant of the facts of child development. However, before the end of the meeting several other possibilities were brought to our attention as, for example, that the mother might have rejected the child and that she was compensating by over-feeding. Furthermore, she might have a more generalized anxiety feeling which at this time was attaching itself to this particular situation. In these latter circumstances it was felt that the mere giving of information would be, at best, of little help.

THE COMPLETE statistical evaluation of a preventive mental hygiene program such as this is probably an unattainable goal but even after some months of such work certain changes have been noted. Supervisors report the use of ideas and technics discussed in seminars in the daily work of a number of our nurses. Written reports on well baby clinic charts are said, in some cases, to be more helpful to the physician in charge whose time is limited for each interview and who finds it desirable to know something more about the personality of the mother with whom he is dealing. Increased enthusiasm and interest in the work have been noted. The follow-up seminars seem to indicate a growth in understanding on the part of the participants in that the discussion tends to become freer, often less elementary and there are indications that less anxiety is being aroused after the direct or indirect expression of negative attitudes toward the leader or other members of the group. There is also some slight evidence that certain individuals are gaining increased insight into their own behavior. In closing I would like to give an anecdotal account of such an encouraging instance.

The nurse came to the mental hygiene consultant for help. For some months the children of a family were no longer being brought to the well baby clinic, where their attendance had been fairly regular. Furthermore the father of the family had been treated at a local hospital for what he reported as a hernia, had been advised to return but had not done so. The nurse's repeated visits to the home, her urgings that they return to their respective clinics had been met only with verbal compliance but apparently no further activity in the matter. In discussion, the fact was brought out that the family probably experienced the nurse's repeated requests as "nagging" and that, as a technic, this was not

desirable. However, inasmuch as the mother of the family seemed to enjoy the nurse's visits, to welcome her warmly and to be willing to discuss the children's welfare with her, it was felt that, if the nurse stayed away altogether, this might be interpreted as punishment. It was, therefore, decided that the nurse should return to the home at regular intervals but should not bring up the subject of clinic visits. It was believed that probably some emotional block, the nature of which was not understood, was responsible for the fact that clinic visits had been discontinued. After a few weeks of the procedure as outlined, the father went to the local hospital and at the next visit he informed the nurse that he was being treated for gonorrhea and not for hernia as he had stated previously. Shortly thereafter the mother returned to the clinic with her children. The nurse reported the development of the case with considerable satisfaction. Several weeks later, when aggression was being discussed, this same nurse, recalling the case described, stated, "On thinking back, I do not think it was simply that the family experienced my repeated urging as nagging. I think that I was so insistent because of my own need to punish them."

SUMMARY

The Division of Mental Hygiene of the Baltimore City Health Department has, during its two years of existence, focused on an in-service training program for public health nurses. They are divided into small discussion groups with approximately ten nurses in each group. The program is described in some detail.

AMERICAN HOSPITAL ASSOCIATION MEETING

The 55th annual convention of the American Hospital Association was held in Cleveland, September 26-29. At the opening session President J. G. Norby stated there is good evidence that hospital administrators have accepted their responsibilities for development of broad health programs in cooperation with other health agencies. This combination of interests involves agencies with similar aims and purposes and will result in improved care of the sick.

At the first general session, speakers representing the public, organized labor, and the federal government advocated the provision of hospital and medical care through existing nonprofit voluntary health service plans such as Blue Cross and Blue Shield. Blue Cross, as the instrument through which the medically indigent could receive care, was advocated by Senator Lister Hill, co-sponsor of the Hospital Survey and Construction Act. The voluntary insurance bill, he said, would encourage voluntary enrollment in Blue Cross and Blue Shield plans, allow deduction for this insurance for federal and other government employees, and set up a means whereby the medically indigent could be covered through federal and state grants.

In Tuesday's general session, Dr. A. Leslie Banks, former principal medical officer, British Ministry of Health, suggested that all hospital administrators study the British Health System and watch it objectively. He pointed out four difficulties met with in relation to the success of the plan: shortage of beds, lack of agreement among doctors and patients about terms and services to be received, the high cost at first which had been under-estimated, and the flood of administrative burdens which came as a result of the sudden introduction of the plan.

Dr. P. B. Magnuson, chief medical officer of the Veterans Administration, declared that private initiative can supply the need for medical care as opposed to federal bureaucracy. He discussed a plan to establish diagnostic clinics throughout the country with the best medical and professional personnel available. The clinics would provide free, part-pay, or full-rate examinations. The cost of the service would vary with the economic status of the patient.

A new 16-minute sound and color 16 mm film entitled "Deed to Happiness", produced by the Southwestern District of the Ohio Hospital Association, was shown. It depicts the high spots in the life of the student nurse and its main purpose is recruitment.

VERY MUCH ALIVE AT ONE HUNDRED AND ONE

IMOGENE SIMMONS, R.N.

THERE SHE LAY curled in an uncomfortable looking ball in the middle of a huge, old-fashioned, double bed. Her hair was clean, but untidy; her face was thin and wizened; her eyes were screwed tight shut. The rest of her was a small tight mound hidden by innumerable bed covers. The room, itself large, was crowded with furniture and appointments of another era. The air was musty and faintly suggestive of lavender, roses, and illness.

At the foot of the bed stood a not unattractive, white haired woman who looked about forty-five and who I knew must be over sixty-five. She never stopped fidgeting and wringing her hands and talking.

"We're awfully proud of her. The poor little thing! What are you going to do, nurse? If she had only stayed in bed that day. I can't imagine how she did it. She fell, you know. Oh, dear, are you going to move her? It hurts her terribly to move, you know. It just kills me to see her suffer. Anna and I just hate to touch her. It hurts, you know. The poor thing! She is just like a little child —can we help? Oh, dear, I can't bear it! Anna, you do better than I do. Can we get you anything, nurse? An enema? Oh dear, I know doctor ordered it, but the pan hurts her so. Nurse, you aren't going to move her? We want to hurt her as little as possible. Moving helps, you say? Prevents pneumonia? Can she get pneumonia just lying there?"

By this time I had my bag set up, had put on my apron and scrubbed my hands. I surveyed the room and prepared to do battle. I hoped I looked capable. My patient did not upset me. I had cared for little old ladies before. And impacted hip fractures with no cast or traction were no new thing to me. But these two women, the jittery, loquacious, elderly daughter and the stone silent, but scared looking housekeeper. They were not to be gotten out the room and little help could be expected from them,—or could it? I wondered. Here was a teaching problem of the first degree and of the kind we all are meeting more and more. Geriatrics is a fairly new word for both professional and lay persons. What it stands for is not new.

There have always been elderly persons around us and they are frequently ill in body or mind, or both. But their numbers are increasing both in our institutions and in our homes and their care is only now coming under careful and analytical scrutiny. Visiting nurses are in a special position for helping in this field. They see these people at first hand in their own surroundings. They meet the family members and friends who must care for these patients; care for them both physically and mentally.

A wanted person usually is a happy individual and a happy patient does not want to die. Wanting to live and be useful and desirable makes an individual less of a burden

Miss Simmons is an apprentice public health nurse in the New York State Health Department who wrote this while having an affiliation with the Yonkers Visiting Nurse Association.

as a helpless patient and more of a family member who needs a little physical help in the business of daily life.

My patient was wanted. That was plain enough. To her daughter she was a museum piece to be cared for gingerly and showed off and talked about. Apparently to her the museum piece was deaf, dumb, and blind, and unless the daughter's unthinking chatter was rechanneled, I felt my patient might decide a decline was preferable to being a living museum piece.

Beckoning to the two agitated women I went into the corridor. Outside a tightly shut door I firmly and rapidly explained that hearing frequently becomes more acute with the bedridden due to concentration.

"But she has been hard of hearing for several years."

"She responds when spoken to," I replied. "You saw that and she has little else to do now but listen and think. Now, I want you to help me, Anna. I am going to give her a complete bath in bed without wetting the covers. I am going to turn her a number of times with as little strain on our back or our patient's hip as possible and the bed can be completely changed in process. Yes, it can be done and you both can learn to do it without me very soon." I read fear and horror in the eyes of Anna, the housekeeper, and my patient's daughter and I felt sorry for them and yet impatience touched me. Two more persons capable of caring for a loved one who would rather pay for a trained person or for institutionalization than learn the rudiments of home nursing, I thought. Well, I was wrong.

Today, five weeks later I entered my patient's room for the first time in a week. I had been going daily and then every other day. She had no bedsores at all. The one which had developed the first week was completely healed. Anna told me that my patient had been up in a chair each day for the past week and that they put her on the commode frequently. They obviously were turning her often and well. The bed was well made, hospital-fashion, and clean. There was a window open top and bottom. The diet that was elaborated for me was well balanced and Anna reported it was consumed with relish. Cathartics were administered regularly on doctor's orders with favorable results.

As I crossed to the bed and spoke to my patient, she opened her eyes and smiled with an alertness and recognition heretofore not shown. "How do you feel today? You look chipper today. I understand you slept well yesterday."

My patient turned her head as I spoke. "Who are you? I am fine. They tell me I fell. When? Can I walk yet?"

I laughed. "Yes, you fell some weeks ago, but you are going to be all right soon. Would you like a bath and a back rub?"

"That would be nice, I think," she replied as I started to shift her position and prepare the bed.

There were no moans or anxious expressions from the patient or Anna as we proceeded with our routine. Anna had learned well how to conceal her own feelings as well as how to make her charge more comfortable. The daughter remained outside the room until we were finished and when called seemed calm and pleased with everything. The patient laughed at our comments and mentioned getting up soon.

"The doctor has been coming three times a week until today, but he won't be here for a fortnight now unless we call him. Thank you, nurse, and we will see you next week sometime?" the daughter spoke confidently.

As I left the home, I felt that more had been accomplished inside than just making one little old lady comfortable for a few hours. She would be kept comfortable in mind and body for awhile to come, and pleased with life.

It can be done.

A MODERN HOME FOR THE AGED

Nurse and social worker describe their place in the professional team that cares for a group of old people under standards that are high from both humanitarian and scientific viewpoints

1. The Nursing Program

BLANCHE D. GUBERSKY, R.N.

AS A SUPERVISOR of nursing service in a home for the aged I have become interested in the expanding field of geriatrics for nurses. There are many implications for nursing education in this. Our staff at the home is composed of the registered professional nurse, the licensed practical nurse, and the attendant. It is a fine opportunity for working out nursing team relationship.

The technical aspect of nursing older people varies very little from nursing other age groups. Our infirmaries frequently are as busy as general wards with a variety of treatments, dressings, and diagnostic procedures. The success or failure of carrying out the therapeutic procedures, however, depends on a general knowledge of reactions of older people and the more intimate knowledge of the personality of the patient.

The knowledge the nurse must have of old people makes a great deal of difference in the total success of her nursing care, as well as the satisfaction and pleasure she derives from her work. Bedridden old people may or may not have friends or relatives. Often the nursing personnel may be one of their few contacts. They, like younger people, have likes and dislikes, their own special interests and patterns that are considerably set. Each older person has his own little world, a world which has been developed out of long years and many experiences. To achieve satisfactory nursing accomplishment those caring for the aged need much more than technical expertness. They must be willing to adapt the many facets of nursing to fit the individual personalities. This is not always so easy as it sounds. It necessitates skill, imagination, understanding, and insight into the characteristics accompanying the aging process. Old people have resources and assets if we take the time to find out what they are. It is the knowledge that each nurse has of the patient that makes for the varying degrees of quality nursing and satisfactory accomplishments in geriatric nursing.

The problem of interesting a sufficient number of professional nurses in geriatric nursing continues to be a difficult one, although there seems to be evidence that their indifference is on the decline if we can judge from the attitude of nursing educators in schools of

Miss Gubersky is supervisor of nursing at the Home for Aged and Infirm Hebrews of New York.

nursing and on the university level. Education of many professional groups and of society in general is necessary to overcome some of the attitudes existing in relation to the total problem of the aging population. I believe these attitudes may be attributed, in part, to a lack of knowledge of the professional satisfaction and pleasure that can be obtained from nursing the aged. It may also be due to erroneous conceptions as to the entire nature of nursing which is done in an institution like this. However, with all the difficulties, it is vitally important to give careful thought to the potential staff nurse for this type of nursing service.

Geriatric nursing is one field in which the practical nurse is an important staff member. Many nursing functions in the care of the aged do not require the professional education and skill of the professional nurse. Practical nurses can carry out many functions exceedingly well under the supervision and guidance of the graduate nurse. Much is said these days about the ratio of professional nurses to practical nurses. I would be inclined to say that in hospitals that care for the aged, the ratio of one graduate nurse to two practical nurses could be somewhat modified, depending upon the activity of the specific unit.

The interview with the practical nurse applicant is planned in such a way as to discern her attitude toward working under the supervision of the graduate nurse. One should not always be impressed with the fact that the practical nurse applicant has had experience with older people, though if all other qualities are commendable, that may be a very desirable feature. One cannot be sure that the applicant who has had experience with older people has the attitudes, the understanding, and the flexibility to adapt herself to the philosophy of nursing the aged that we want in this institution.

The first day a practical nurse is in the Home, the supervisors plan their program in order to be able to give her an introduction to the Home as a whole, and a more detailed orientation to the unit to which she has been assigned. She does not work alone the first few days, but works with those people whom we recognize to be valuable persons on our staff. During the first month, individual conferences for her are planned by the head nurse of the ward, and if necessary, by the supervisor of the nursing service. We hope, in these conferences to help the practical nurse with problems we have observed in her nursing and in her manner with the patients. We try to help her understand more fully the reasons for specific routines and the personalities of some of the patients.

We are slowly developing a program of in-service education for the staff nurses. Recently we had a demonstration of the correct use, handling and care of oxygen equipment. Occasionally arrangements are made to show films that particularly pertain to our work, such as the care of the cardiac patients. As new equipment is introduced to the service, such as penicillin inhalers and the thermotic drainage pump, we plan to demonstrate the correct use of the equipment either to groups in a classroom or at the bedside of the patient. At the Home we subscribe to several nursing periodicals, and as articles about the aged appear in these magazines, we post notices in strategic areas in order that the nurses will know about these articles and read them. We encourage the use of the professional library. Practical nurses are encouraged to take the refresher courses now offered by the Practical Nurses of New York. If necessary, variations are made in their time on duty so that they may avail themselves of this opportunity. Within the past five months, eight of the practical nurses have taken such refresher courses. It is important to include them in various aspects of the program in order that their interest is stimulated and sustained and to show them that we are interested in them as members of our staff and not merely as people to do the work. Activities of the aforementioned nature contribute to the element of stability in the staff and again that is a necessary factor in the care of the aged. Since old people have great difficulty in accepting change, no matter how small, a stable staff is one factor that is considered important in geratric nursing.

Educational programs are offered to professional nurses outside the Home. For the past two years we have had the privilege of extend-

ing our clinical educational facilities to students in the Medical-Surgical course of the Division of Nursing Education of Teachers College. Judging from the reactions of the groups we have had at the Home, we feel that it has not only benefited the affiliating students, but that in their future contacts with student nurses, they will present the whole concept of geriatric nursing more attractively.

I would like to speak briefly about our responsibilities concerning the well being of our healthy aged. In the entire health field we are no longer satisfied to confine our care to the treatment of illness. We try, whenever possible, to prevent it. In the clinics, in our frequent rounds through the house, and in the many contacts we have with groups of residents, we have an excellent opportunity to observe the residents carefully. We may notice changes in appearance, in color, weight, general vitality, and physical ability. One case, which occurred within the past two months, is worth brief mention. Mr. A., a resident of the Home for six years, had suffered amputation of the right leg before admission, but has been in good health since entering the Home. Members of our staff noticed that Mr. A. was losing weight and had poor color. He was asked to come to the clinic and following examination, was admitted to the male infirmary. His hemoglobin was 22 percent and a large abdominal mass was felt. After a careful study including five blood transfusions, he was transferred to Mount Sinai Hospital where an exploratory laparotomy was performed. A subtotal gastrectomy revealed a benign tumor —and in 10 days he was returned to us. Mr. A. is in excellent condition today and is once again able to indulge in his favorite and productive hobby of painting.

Nurses are not the only staff members who assist with our program of sickness prevention. The dieticians may observe factors in the dining room that possibly reflect a change in the resident's condition. The same is true of members of the social service department, housekeeping, and administrative departments. We follow up all these observations by calling each one to the attention of the physicians in the medical department. We encourage the residents to visit the clinic for ambulatory patients, where they may see and talk with the resident physicians. It gives them a sense of security to know that this care and this concern for their welfare is a planned activity of the medical department.

In closing, I would like to say that the entire medical program at the Home is unusual in its aggressive attack on the physical and mental health problems of the elderly. This is the result of the enlightened leadership of our medical staff and the real team spirit of our whole organization.

2. Social Service

VERA M. BURKE, PH.D.

MEDICAL SCIENCE has done much to prolong the life span of our population. In order to meet the needs of the ever increasing aged group, professional social workers have a responsibility to examine our role and evaluate our function in relation to these people. In our Home the tradition of the social worker dates back over 20 years when Mrs. Emma W. Lewi became the first professional worker in an institution of this kind. The functions

Mrs. Burke is on the staff of the Social Service Department of the Home for Aged and Infirm Hebrews of New York.

of our Social Service Department are divided into two categories (1) application procedure and (2) activities for the resident.

Application procedures are as follows. A scheduled appointment is arranged between the applicant and the worker. The applicant is encouraged to come in and make his own application. Only in instances where he is non-ambulatory do we make the initial contact with children or interested relatives. In such situations, however, a visit is made to the prospective resident in order to get an impression of the individual and his needs. During the initial office interview between the applicant and the worker we allow sufficient time to enable the client to have an opportunity to verbalize his feelings in relation to his present problem, to express as fully as possible his reasons for seeking admission to an institution, and to raise any questions that he may have about congregate living. It is our responsibility to interpret the differences in congregate living from life in the community and to point out not only the advantages but also its limitations.

After we accept the application and secure whatever medical data may be available about the client from outside clinics and private physicians, he is examined in our Medical Department. The medical recommendations determine medical eligibility and for what faculty in the Home the client seems most suited. We work very closely with the Medical Department in interpreting these recommendations to the prospective resident and in making the best possible placement within the Home. The most important phase of our application procedure is the home visit. We feel that to see the client in his own home setting enables us to understand more fully what he is giving up in relation to what he will get in the Home. We are also better able to determine the client's standard of living, finding as we often do that clients make special preparations for an office interview and look quite different in their own homes.

The children and close relatives of the prospective residents are seen in order to evaluate their role in the applicant's decision to come to the Home. Very frequently our contact with the children brings to light many other problems in the total family situation wherein we can be helpful and indirectly help our applicant.

There is no financial entrance requirement. The present financial arrangements for admission are as follows:

1. A client must, upon his admission to the Home, assign all his assets to the Home to be amortized at an agreed upon rate.
2. If no assets are available the children or responsible relatives are asked to assume financial responsibility in accordance with their ability to do so.
3. If these children are unable to meet the minimum costs, the client is referred to the Department of Welfare, for supplementary assistance in the form of Old Age Assistance grants.
4. If there are no responsible relatives the Department of Welfare assumes full responsibility.

Every effort is made to select out of all our applicants those whose needs are greatest in relation to the services that we can render. We find frequently that in studying the cases we are able to help the applicant accept another plan which better meets his needs and at the same time releases a bed in our institution.

At present we receive 600 to 700 applications a year and we anticipate an increase in this number due to the ever increasing life span of our population. We have at present 525 persons pending admission to the Home and our turnover, because of the great advances made by our Medical Department, accounts for 50 to 60 admissions a year. This is a very bleak picture in relation to the need and we know that the community has not kept abreast with medicine in providing facilities to meet the needs of the aging population. As social workers we have a responsibility to bring this to the attention of our community leaders in the hope that this situation will be remedied.

Shortly before a person is to be admitted to the Home he is again seen by us and prepared for admission. This gives him another opportunity to see himself in a changed situation and to determine again whether placement in the institution is really what he wants. Once in the Home it is our responsibility to acquaint the new resident with the institution and to stand ready to handle problems that arise out of this new way of life. We make every effort to place people in a congenial setup with suitable roommates. Often, however, dis-

agreements occur and we have to move the resident several times before we find a suitable roommate for him. It is interesting to note such problems are more prevalent among the women residents. We feel that the reasons relate to the sudden loss of household responsibilities carried over a long period of time when the woman was mistress of her home. She suddenly finds herself needing to share facilities with other women, each one wanting to be the boss. Problems come up around certain rules which must be obeyed if one is to run a large institution for the greatest good of the greatest number. For example, residents are not permitted to smoke in their rooms. They are also not permitted to have a pet. One couple who were in the Home several years, decided that they would like to have a canary and because this was not permitted left the Home.

The social worker has to acquaint the new residents with the various departments in the Home and interpret the role of these departments in relation to the resident's needs in the Home. The Hospitality Committee consisting of residents welcome the newcomer on his arrival, introduce him to his roommates and tablemates, and try to make him as welcome in the group as possible.

The activities program in the Home provides means for a useful existence. The Medical Department recommends what work a resident can do without injury to his health. He is then assigned to perform these tasks in accordance with his physical ability and his mental capacity. The library is staffed entirely with residents. Many help in the laundry, deliver messages, sit at the door, and work in the Occupational Therapy Department. The Home Club provides a social life for the residents, giving them an opportunity to get together at regular weekly meetings. They elect their own officers and air some of the problems common to all, such as the need for another pay station on the second floor. A recreational adviser plans the entertainment, utilizing Home talent and providing sources of entertainment from the outside through concerts, movies, and bingo parties.

Changes in the resident's health situation often present problems which we can best meet with the help of the Medical Department. They work cooperatively with us in interpreting both to the resident and the relatives the change that has taken place and the need to adjust to this change in terms of moving from a room to the dormitory, the infirmary, or sometimes even an outside hospital where treatment is to be given.

The ever changing costs in operations and in circumstances of people necessitate changes regarding financial arrangements and it is the social worker again who is called upon to reevaluate the financial position of the relatives and make whatever adjustments are indicated in the situation.

Within the last year we in the Home have embarked on a new program for the care of the aged known as the Home Care Program. You will hear more about this type of care from the American Red Cross and general hospitals who have developed such programs for their patients. Briefly, to us Home Care represents an extension of the institution's services into the home of the client. By remaining in his own home thus relieving the pressure for beds upon the institution, the client is given the same amount of security that he would derive if he were in the institution and knows that we stand ready to serve him in an emergency under any circumstances. In this program housekeepers provided by the Jewish Family Service are made available as they are needed and the recreational facilities of the Home are open to these people to use as part of their social life within the community. We also make full use of existing community agencies such as the Visiting Nurse Association and general hospitals to implement our work with these Home Care residents.

In summary it may be said that the Social Service Department in the Home is an integral part of the community's effort to meet the needs of our aged populaion. We are ready to modify and improve our methods in order to give the greatest amount of service to the greatest number of people.

A STEP TOWARD BETTER VOCATIONAL REHABILITATION

CHARLOTTE R. BURMEISTER, R.N.

LIBERTY Mutual Insurance Company, in compliance with the overall program of rehabilitation of injured workers, employed several registered nurses with experience in industry, public health work, and orthopedics to carry the rehabilitation work into its branch offices. Such a program was begun in Baltimore on October 5, 1948. It would appear that Baltimore with its excellent medical facilities and large industrial plants would be an ideal city to instigate such a program. However, as is true of any new program, the plan was viewed by management, the medical profession, and the employee himself with enthusiasm and cooperation tempered somewhat with pessimism and skepticism. Some others were completely indifferent. It is still a little early to present a detailed report of our results. Some of the cases handled have returned to work; others are still receiving therapeutic treatment; and still others are accepting counseling and vocational guidance. The purpose of this report is to describe the work that is being done, and outline our future plans. At the same time, I hope to point out the obstacles in our path in the hope that so doing will better clarify our position, and perhaps help others doing similar work.

Without the aid of her fellow workers,—the claims adjuster who has the first contact with the injured employee, the compensation supervisor whose job it is to see that the patients are followed and referred properly, and the claims manager whose influence and contact with management are of extreme value, the rehabilitation nurse, no matter how sincere about her work, would be completely lost. If the coworkers in her own organization are sold on the value of rehabilitation then she is much more confident of her approach to others. Frequent medical conferences with the medical advisor at which time x-rays are reviewed and injuries and the long range plans discussed regarding the injured worker are of the utmost importance. It is at these conferences that various common patient problems come to light, and so enable the rehabilitation nurse to recognize and meet the problems she may encounter. A skeletal and muscle chart hangs nearby to aid both the professional and the lay worker in understanding the medical aspect.

We are fortunate in Baltimore in having two well known medical schools and many good hospitals. The facilities of the Curative Workshop of the University of Maryland are available to us, and we use the shop frequently to supply occupational therapy to injured workers. Here the patient not only regains bodily function, but also works side by side with other disabled people. The psychological effect is good. In such surroundings,

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the patient receives direction and help, not pity. This tends to make him work harder and think of his disability as something that can be overcome. The workshop is operated as an out-patient clinic. The frequency of treatments depends on the patient's physical tolerance, because as the work tolerance increases the work load is increased. The clinic is so set up that the patients are able to receive physical therapy in the same building. One of the obstacles we have run into has been the increasing shortage of trained physical therapists. It has become extremely difficult to secure physical therapists to carry out this important work.

As the program has gained momentum and has become better known, patients have been referred to the rehabilitation nurse by plant doctors and other nurses. Individual doctors have also referred patients whom they thought the nurse might aid.

We still have a long way to go in educating the public, medical profession included, in the need for rehabilitation. The Vocational Rehabilitation Service have an excellent film entitled "Comeback", which demonstrates this need admirably. Education of the public by such films is sorely needed.

We have been working very closely with the State Vocational Rehabilitation Service, and they have been of service not only in aiding disabled workers in vocational training, but also in giving the claimants impartial counseling and thus helping them to look at their disability objectively. In severe cases where the disability is great, we make use of the excellent facilities of the Woodrow Wilson Rehabilitation Center in Fishersville, Virginia. Here the disabled worker receives physical therapy, occupational therapy, and vocational training at the same time. He may choose one of twelve schools in which to learn a trade. After completing a vocational training course at Fishersville these disabled workers are not amateurs but skilled workers well equipped to earn a living in the competitive world.

Those of us interested in rehabilitation work are realizing more all the time the need for vocational training as well as physical therapy and occupational therapy. If a disabled worker cannot return to work and earn a livelihood, then our rehabilitation program is incomplete and not of much value. Nothing is more gratifying to the rehabilitation worker in following up a patient, than to be told the claimant has returned to work. Sometimes employers are apt to "make a place" for the worker. This is done with good intentions, but too often the worker is not properly trained to overcome his handicap and consequently is just retained by the employer because he feels sorry for him. This is not helping the employee for he knows he is not doing a full day's work, and this has a bad psychological effect upon him. In times of economic stress these workers are the first to be laid off and it is such workers that need a job so vitally to maintain their security. With proper training and placement, disabled workers can be competent employees.

Another obstacle we encounter in getting the claimant back to work involves his union classification. If an injured worker is a steel structural worker and his doctor permits him to return to light work, frequently his union will not permit the employer to put the employee back to work, because the work provided is not his regular trade and so involves a different pay rate. Such a ruling has a demoralizing effect on the worker and paves the way for "compensation neurosis." Undoubtedly, the rule serves a good union purpose, but when adopted, it did not take into consideration the plight of handicapped workers who need assistance and adjustment in returning to productive employment.

Some of our compensation laws do not lend themselves well to rehabilitation. Management should have some incentive to employ disabled workers. In virtually all states the law provides that an employer is responsible for aggravation of a preexisting injury or condition. Hence, an employee with a previous back injury may be turned down by a prospective employer. Appropriate placement of the man, however, into work consistent with his condition and periodic physi-

cal checkup could make him not only a safe but productive worker. The enactment of additional laws to cover "second injuries" is regarded as a practical solution to the problem of employment of handicapped workers. In the absence of statutory provisions to cover this contingency an employer might be influenced to refuse employment to handicapped workers. Many cases are rated under the compensation laws as permanently totally disabled. This rating is an attempt to recognize the great economic loss. Permanent total disability is compensated at the computed rate for life, for a term or total amount, or both. In cases where the payments are permitted to drag on for life quite often the incentive of the injured worker to help himself has been destroyed. With modern medical methods and advanced vocational rehabilitation programs, there are very few persons who are completely disabled from a medical standpoint. At the Woodrow Wilson Rehabilitation Center, I saw paraplegic cases learning watch repairing. Certainly these patients were better off emotionally as well as physically by learning a trade and thus becoming useful citizens. Perhaps these cases are the exception rather than the rule, but if such training can help this type of disability, it can help others.

This is the way some specific cases have been handled by Liberty Mutual.

CASE I.—Mr. G, a 45-year-old man, a tractor driver, was injured November 4 when he fell approximately 12 feet into the hold of a ship. The patient sustained extensive injuries of his right arm necessitating amputation three inches below the right elbow. The claimant was discharged from the hospital December 6. On December 12 he was readmitted to the hospital when he suddenly developed a temperature accompanied by severe chest pains. It was diagnosed that the patient had suffered a pulmonary infarction with pleural effusion. The pleural cavity was aspirated and about 1000 cc. of bloody fluid obtained. The patient was treated with penicillin and dicumarol therapy and progressed satisfactorily. He was again discharged from the hospital on January 7. On February 15 the stump was sufficiently healed for the patient to begin physical therapy. After the stump was adequately shrunk, the patient was measured for a prosthesis. As soon as the prosthesis arrived, the patient began occupational therapy at the Workshop. He was discharged May 27 and returned to work June 1.

This case was followed closely by the rehabilitation nurse. Her first visit to the patient was made while he was still confined to the hospital. In that initial visit plans were outlined to the patient regarding his future care. Much is gained by early contact with disabled employees. This patient had an excellent mental attitude and accepted his disability as something that was accidentally incurred. His main worry seemed to be whether or not he would be able to operate a hook sufficiently well to support his wife and two children. While convalescing he practiced writing with his left hand. When he received his artificial arm, the rehabilitation service was notified and he began penmanship classes. When he had completed his classes, he was ambidextrous and could write with the hook as well as with his left hand. To get further practice he painted a picket fence holding the brush with the hook.

In the meantime the nurse called on the employer to discuss plans for the patient returning to work. Prior to the injury the man drove a tractor for a large stevedoring outfit. This necessitated heavy lifting. It was felt wise to change the employee's job to something involving less lifting. As the employee was above average in intelligence, he easily fitted into the position of pier foreman. Here he was able to supervise the loading of ships keeping an eye on the men operating the tractors. This work he knew for he had done it all his life. His new job entailed keeping accurate records, but as he had learned to write, this was not a difficulty.

The last time the nurse saw the patient, he was working a full day at a full day's wages. All cases aren't this serious, nor do all cases have this happy ending.

CASE II.—This case involved a 38-year-old telephone linesman, who suffered a severe spinal injury when he fell 20 feet. This patient has considerable permanent disability and it was evident that he would never return to his former occupation. The patient was discouraged and depressed. The nurse in one of her visits to the patient discovered he was interested in woodworking. She convinced him he might easily make this his vocation instead of his avocation. Arrangements were made with the Rehabilitation Service to have the patient admitted to Woodrow Wilson Rehabiliation Center for vocational training. The patient is undergoing this training at the present time.

CASE III.—Recently a patient who had suffered a stroke while at work, was returned to his home after he had reached his maximum amount of improvement. The patient will never be able to work again and gets about the small apartment in a walker. The nurse worked out plans for home care with the patient's wife. The patient follows a well planned routine, and is able to do many little things for himself.

The plans also include dietary help to aid the patient to keep his weight down but his nutritional status up. Added weight at this time would only be an added burden.

Many patients with fractures, although no permanent disability is involved, are visited by the nurse. This gives the patient convalescing at home a feeling that someone is interested in his well-being. Frequently the doctor will release the patient to light duty, and the nurse acts as the liaison between the doctor and the employer, helping to see that the claimant receives the right type of work. This is of extreme importance for many fracture cases are able to rehabilitate themselves if permitted to return to some sort of light work before they begin their regular duties.

SUMMARY

The restoration of earning power through rehabilitation of injured workers serves both a humanitarian and an economic purpose. By separate enactment the states having workmen's compensation laws have accepted specifically the benefits and provisions of the Federal Vocational Rehabilitation Act. This act provides a federal fund to assist and rehabilitate those disabled by accidents in industry as well as those disabled from other injuries or congenital anomalies. It provides for vocational rehabilitation and for necessary surgical and hospital services. The federal and state programs for rehabilitation have been helpful as far as they go, but the main responsibility certainly belongs to management. Individual industrial organizations must make their own deliberate effort towards rehabilitation of their own injured employees. It is not expected that management do this alone, but work with the employee, the doctor, the rehabilitation nurse, and the Vocational Rehabilitation Service. To continue with such a program, we as one of the largest underwriters of compensation insurance, must continue to educate management and the general public to the need for vocational rehabilitation.

Unfortunately the attitude in the past toward the severely handicapped has been one largely of sympathy and charity. As a result many disabled people accepted pity and charity and thus considered themselves helpless and dependent. Such an attitude was wrong and had a tragic effect upon the handicapped worker. It was not until the advent of World War II that industry generally began employing physically handicapped workers. This was a big step forward in rehabilitation. We realize now that if *properly trained and placed,* handicapped workers are not bad risks.

WHY NOT START WITH THE PEOPLE

HAZEL WEBB, R.N.

IN ANY community project where people are involved, you must start with what you have. Not only the character of the people but the local customs and convictions, perhaps more noticeable in rural work, will be the first and most reliable guide to the direction of your planning. The person who goes into a community so wrapped up in his own dream of accomplishment that he fails to learn those customs will almost certainly meet serious resistance. He must work with the people as he finds them, giving credence to their beliefs and considering their problems as they themselves see them.

This is what I mean. Several years ago, when I was quite young in public health nursing, I went into a rural home to talk with a mother about immunizations for her two preschool age children. They had not been protected against diphtheria or smallpox, although they had had the "fever shots". I had rehearsed my little talk, and knew exactly what I was going to say to her. When she came to the door in response to my knock, this is what really happened:

"Mrs. Waldrup? I am Miss Webb, the nurse from the Health Department. May I come in?"

"Sure, come on in, Miss . . . Webb, did you say your name was? Take that chair over there."

"Thank you. How have all of you been getting along?"

"Why, all right, I guess. I expect you want to see the younguns, don't you? Well, they're not here right now . . . went with their father down to the neighbor's to see if he had anything to kill bugs on cabbages. Our cabbages have bugs bad. 'Fraid if we don't get something soon to kill 'em, we won't have any kraut this year. Do *you* know how to get the bugs off the cabbages?"

"No, I'm afraid I don't. Mrs. Waldrup, in looking over Tommy's and Helen's health records, I found they haven't had their protection against diphtheria and smallpox yet. They need them, you know, and . . . "

"Ummmm, is that right." She walked to the door and peered out. "Seems like they oughta be coming back by now. 'Course I guess one of those government men in the courthouse in town could tell us how to kill those pesky bugs, but we don't have a way to get into town. . . . Always put up about a hundred quarts of kraut every year. . . .Do you think Paris Green would poison the cabbage leaves, if we used that?"

"It might. It would get down into the head, you know, and it *is* poison. Now, about the diphtheria protection . . ."

She heard the rattle of the wagon, and ran outside as her husband jumped down. I couldn't hear what he said, but it was evident from the expressions on their faces that he had obtained no help. It also became evident to me that today was no time to talk immunizations. They were in no mood to listen, with such serious threat to their winter food supply. I went outside, too, abandoning my

Miss Webb is on the nursing staff of the Hardin County Health Department, Savannah, Tennessee.

preconceived arguments, and said to them, "Maybe I can help you about your cabbages. How would it do for me to call the Farm Agent this afternoon when I get into town, ask him what you should do, and write you a postcard? You'll get it in the morning."

They were delighted at my offer. I kept my promise, the cabbages were saved, and I had created a valuable entree not only into that home, but into many others in the neighborhood. The children were duly immunized, and to those who fear the consequences of friendly acts, I can say that the people did not take advantage by expecting endless favors. That taught me a lesson about fitting myself to the needs and wants of the community, instead of expecting them to jump up and click their heels, so to speak, because I had such excellent health teaching to offer them. In fact, I remember it so well that I can still, today, tell you how to get the bugs off cabbages!

A YOUNG NURSE I knew was given a difficult situation to handle. A teen age boy had a bad crippling condition of his legs, one that could have been helped considerably by orthopedic surgery. His father was violently opposed: "The Lord made him that way, and it's just a cross we gotta bear. I don't aim to have no doctor a-cuttin' on him!" Many nurses had tried and failed. This young nurse had never been in the home, but she knew the history. As she drove up to the house, she noticed that this man's corn crop was beautiful. The corn was taller and greener and richer looking than any of his neighbors'. When she went in the house, she chatted pleasantly for awhile about this and that, just nodding and smiling to the boy when he dragged his poor legs into the room. The father sat by the window with his hat jammed down to his eyebrows, chewing tobacco. His glance swept the nurse and the boy and his jutting chin dared her to say the words "doctor" or "operation". She coolly rocked and chatted, finally mentioning the cornfield, and saying how husky it looked —fine corn—and how fond she was of it. Would the man sell her a dozen ears? His jaw dropped till he almost lost his wad of tobacco, but he sent for the corn. She paid him for it and went on her way. A few days later, she stopped by, so she said, to get some more of that delicious corn! A week later, she stopped again, and this time, the man brought up the subject of the boy's legs. He was scowling, but there was a twinkle in his eyes.

"Guess you think I'm just an ornery ole cuss, don't you, nurse?"

She grinned. "Of course you're an ornery old cuss. When are you going to stop being one?"

"Well, it's kinda hard to stop, at my age. Can they really help the boy?"

Two weeks later, the child was in the hospital, breathlessly hopeful of a good pair of legs, and the old man called this nurse his friend. This sounds like a sob story, I know, but it is true. It happened because the nurse was not belligerent about selling the doctors and surgery—fearful words to that family. Had she gone in and immediately started presenting arguments, no matter how excellent, she would have failed to help that boy.

IN OUR PART of the country there is a rather high degree of illiteracy among the poor white and Negro adult population. They know very little about health and sanitation, and they see no reason for learning. They are afraid. A comment like this is not unusual, "Naw, sir, I don't want one of them Ess-Ray pictures took o' my chest. Why, Sam Bond's wife was porely, but she wasn't to say sick until she had one of them Ess-Rays made. Three months after that, to the very day, we all went to her funeral. Died of tuberculosis, doctors said. Naw, sir, not for me!"

It was because we knew of this attitude that we were not sure how successful our new mobile unit x-ray would be. Ours is an area of farmers, with a few factory workers and tradespeople. Those groups, plus their high school children, were the ones we particularly wanted to screen for tuberculosis. Tennessee is among the six highest states in the country as to tuberculosis mortality rate. Whole families are devastated by it. Hospital facilities are not nearly adequate, although three big new hospitals are being

built now. Until they are completed, the best we can do is find the disease in the early stages, and then do a job in education for care at home.

Six months before the unit was to arrive, we spent hours planning how best the program could be sold. We were most fortunate in having the "Little Club" to help us. This is a group of 25 young matrons whose sole club purpose is to do volunteer work in tuberculosis. They plan the Christmas Seal sale and personally collect the money. For the rest of the year, they pay out that money, mostly for hospitalization, exclusively on the recommendation of the health department. It is the smoothest functioning and most interested group I have ever worked with. Besides being interested, they have the added advantage of their social contacts. They can go to the president of this or that company and say, "Jim, Bob and I should like very much if you and Mary will have dinner with us tomorrow night. Will you? Oh, and by the way—I've put you down for $200 for the Christmas Seals. Do you want to give me a check now or mail it to me?" It works.

So we called on the Little Club president to help us plan. She immediately said that a committee of women would approach every plant manager in the vicinity to find out how many employees he had. That way, we could set up the coach half-way between small manufacturers, and plan units of work in terms of days. She planned still further ahead. When we got definite word about the day the coach would come, she would have her group personally visit every owner or manager, and explain and sell the service we were offering. Oh, yes, and her publicity chairman could use any publicity posters or other advertising material we could get.

That settled the plants. We left preliminary arrangements entirely in the capable hands of these trained volunteers, and reported back and forth as the plan developed or we got new information. The nurses were free to arrange for the rural communities. This was done by talking with magistrates (county court members, powers in their communities), store-keepers, postmasters, PTA presidents, and so forth. The school superintendent gave us permission to present the information to the next teachers' meeting and we had no difficulty there.

The program was a success, so much so that the follow-up work swamped the nurses for months.

As I look back, the project seems to have been accomplished by fairly good organization. It might have been better had we had more groups present in the initial planning, but the Health Department and the Little Club worked together, and each group did the part for which it was best equipped. We lacked their entree to the plant owners, and they could not have had our good working relationships with the magistrates and the school administration.

These little stories I have told actually have but one thought,—you must start where the people are. An aloof person, with a scientifically perfect plan which he intends to superimpose on a rural community, will get exactly nowhere. A friendly, genuinely understanding person—one who will talk with and listen to the people—even if he has to compromise a little in the beginning, will almost certainly win with that plan.

PUBLIC HEALTH is a purchasable commodity, available in large or small quantity, in a variety of packages, and its value increases after purchase. It is a difficult article to place on display or to sell on the auction block. Public health is reluctantly bought, but once secured is not given up. It is an indictment to our intelligence that public health's best salesmen are major disasters or epidemics of disease.

—FOREWORD TO BIENNIAL REPORT OF THE IDAHO DEPARTMENT OF PUBLIC HEALTH, 1947-1948.

HOW WELL DO YOU EAT?

GERTRUDE · AUSTIN

NO ONE CAN SAY exactly how much you should eat—especially in an article for all Public Health Nurses. "You" are plural. Some of you are young—some are old. Some are short—some tall. And sad to say, some Public Health Nurses are too thin and some are more than "pleasingly plump". A few of you live alone—and like it, we hope—and some of you have families. Many of you eat "out" and practically all of you lunch away from home. In other words "you" are a pretty good cross section of our female population—so a general discussion of nutritive needs could be practical for you *or* your patients.

Good nutrition after all, is a matter of good eating. And for real down to earth satisfaction give any woman the job of providing good eating for her family—even if her family is only herself plus an occasional friend. Attractive, nourishing, satisfying meals fortunately are possible at moderate cost if you choose foods wisely.

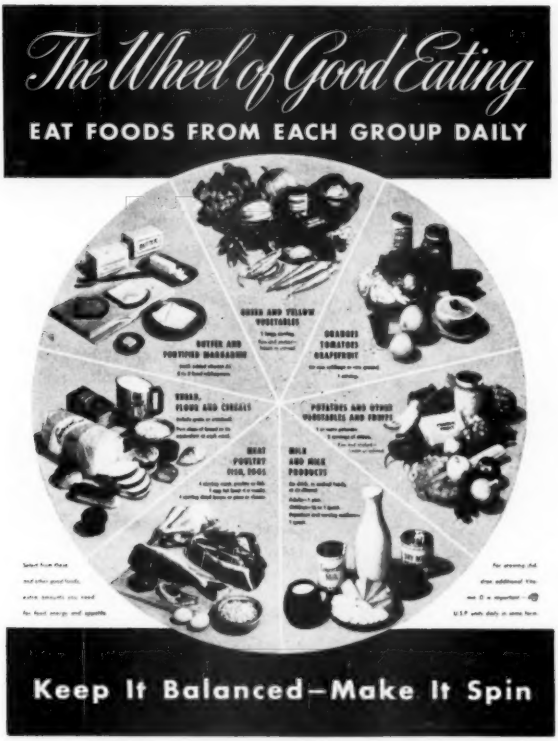
It is a fine thing to have scientific information on the nutritive needs of us humans. But nutrition is so personal. And so few of us really practice what we preach about nutrition. You Nurses actually have a head start in the feeding-yourself department. You can be technical—and at the same time practical—in advising patients on nutritive needs. You teach them all the rules because they must have the right foods to regain health. But think of yourself for a moment. Do you practice what you preach? Your health is the foundation of your job; without it you're not worth much. And don't we hear you telling teen-agers about the relationship between the food they eat and their date-ability, attractiveness, pep, and the like? Every one of us wants to be attractive—whether the date-ability enters in or not.

The personal nutrition problem resolves itself into something like this: Every day people need certain nutrients or values that are found in foods. These nutrients are called calories, proteins, minerals, and vitamins. But most people lack time or interest to learn and remember much about these nutrients and the foods that are rich in them. So we take as our guide the basic seven food groups, which have been worked out by scientists to make it easy to select an adequate diet.

These familiar foods pictured in "The Wheel of Good Eating"—on page 595 are the backbone of health for every human being. All of them are important. Some are especially rich in one nutrient and others are rich in many. Every day it is wise to eat foods from each group for buoyant health.

There is good common sense in the basic seven foods idea. In this "Wheel of Good Eating" we have an easy-to-use device for checking mealtime adequacy. To make it

Mrs. Austin is director of the Nutrition Education Department of the American Institute of Baking, Chicago, Illinois.



simple, the kind and amounts of each of the essential food groups needed each day are included.

GREEN AND YELLOW VEGETABLES

Green and yellow vegetables have many minerals and vitamins. They are rich in Vitamin A and iron. Dark green vegetables, such as spinach, greens, broccoli and the outer dark leaves of cabbage are rich in iron and Vitamin A. Carrots, squash, peas, string beans, and sweet potatoes are also rich in these nutrients. In fact, all green and yellow vegetables are important in diet construction. You can tell pretty well from their color how much food value they have.

ORANGES, TOMATOES AND GRAPEFRUIT OR CABBAGE OR RAW GREENS

The foods in this group have large amounts of Vitamin C—the nutrient that prevents scurvy and is needed for healthy teeth and gums. Strawberries and cantaloup, in addition to citrus fruits and tomatoes, are rich in Vitamin C. Tomatoes and tomato juice have about half as much Vitamin C as citrus fruits so you need to use more. You do well to plan to have at least one good serving of these foods every day, fresh, frozen, or canned.

POTATOES, OTHER VEGETABLES AND FRUITS

In this group are many fruits and vegetables which you should have every day. With them you add goodness to meals and building materials for your body. Potatoes are especially valuable—they give surprisingly high returns in nutrition for their cost. Every day have at least one potato and two servings of the other foods in this group, canned, frozen, or fresh. And cook vegetables just long enough to make them tender.

RICH FOOD SOURCES OF THE NUTRIENTS

VITAMIN A

Good sources of vitamin A are: *

Liver	Greens	_____
Sweet Potatoes	Apricots	_____
Carrots	Tomatoes	_____
Spinach	Peas	_____

In addition other green and yellow vegetables, whole milk, yellow cheese, butter and fortified margarine are sources of vitamin A.

THIAMIN (B)

Good sources of thiamin are: *

Pork, Lean	Bread Enriched,	_____
Liver	and Whole	_____
Peas, Green and	Wheat	_____
Dried	Cereal, Enriched	_____
Beans, Dried	Whole Grain	_____
	and Fortified	_____

In addition heart, soybeans, lamb and green leafy vegetables are sources of thiamin.

NIACIN

Good sources of niacin are: *

Liver	Bread Enriched,	_____
Chicken	and Whole	_____
Lamb	Wheat	_____
Tuna Fish	Peas, Fresh	_____
Peanut Butter	Green	_____

In addition other lean meat, poultry, canned fish and enriched cereal products are sources of niacin.

RIBOFLAVIN

Good sources of riboflavin are: *

Liver	Meat, Lean	_____
Heart	Eggs	_____
Milk	Chicken	_____
Greens	Beans, Dried	_____

In addition tongue, enriched bread, turkey, cheddar cheese and salmon are sources of riboflavin.

VITAMIN C

Good sources of vitamin C are: *

Orange	Strawberries	_____
Grapefruit	Potatoes	_____
Tomato	Cabbage	_____
Greens	Green Pepper	_____

In addition other berries and cantaloupe are sources of vitamin C. The foods should be fresh and prepared just before serving. Eat vitamin C foods raw when possible.

VITAMIN D

Good sources of vitamin D are: *

Foods Fortified with Vitamin D	Fish Liver Oils	_____
	Vitamin D Concentrates	_____
		_____

Sun shining directly on the skin helps the body make its own vitamin D.

PROTEIN

Good sources of ANIMAL and VEGETABLE protein are:

Meat, Lean	Cheese	Bread, Enriched
Fish	Peas, Dried	and Whole
Poultry	Beans, Dried	Wheat
Eggs	Soybeans	Cereals, Whole
Milk	Nuts	Grain and
		Enriched

Eat some ANIMAL protein each day.

CALCIUM

Good sources of calcium are: *

Milk	Cheese, Yellow	_____
Kale	Mustard Greens	_____
Collards	Turnip Greens	_____

In addition dried beans, nuts, self-rising flour and enriched self-rising flour supply some calcium.

IRON

Good sources of iron are: *

Liver	Molasses	_____
Meat, Lean	Sorghum	_____
Eggs	Dried Fruits and	_____
Greens	Beans	_____

In addition heart, kidney, whole grain and enriched breads and cereals are good sources of iron.

IODINE

Good sources of iodine are:

Iodized Salt
Sea Food (Salt Water Fish)
Green Vegetables, Milk and Water in Areas Where Soil Contains Iodine.

*Use blanks to record local plentiful foods.

IF OVERWEIGHT, SEE YOUR DOCTOR

COOK FOODS IN AS LITTLE WATER AS POSSIBLE JUST LONG ENOUGH TO MAKE THEM TENDER

Source: American Institute of Baking

MILK

Milk is always important and it is real economy to use a pint and a half a day. Milk is rich in calcium and protein. Other food values of milk help protect health. If you are watching your weight, better use skim milk because the calories of whole milk or cream are high. Dried skimmed milk is real bargain food—and good too.

MEAT, POULTRY, FISH AND EGGS

Meat, poultry, fish, and eggs are rich in protein, and also in minerals and vitamins. Every day plan to have one serving of meat, poultry, or fish. Liver, heart, kidney, and other organ meats are especially important. Have them once or twice a week. Also have one egg each day if you can, but at least four or five a week. Eat peanut butter, nuts or dried peas or beans often.

BUTTER AND FORTIFIED MARGARINE

Butter or fortified margarine make your foods taste good, and help out from the standpoint of nutrition. If you are of normal weight, use two to three tablespoons daily—but, be stern with yourself if you weigh more than you should. Also remember to remove all fat from your meat if you are working on the weight problem and shun cream, oil, nuts, and fried foods.

BREAD, FLOUR AND CEREAL

It is just good planning to include about two slices of enriched or whole grain bread at each meal. Since many of us are interested in the weight problem, it is wise to remember that bread is no more fattening than any other food of equal calorie value. However, butter and other spreads can more than double the calorie value of one serving, so be careful to use no more spread than needed. Even in reducing diets, three slices of bread a day can be included, one slice with each meal because it goes so well with other foods and adds valuable nutrients. Bread has more than its share of three important B Vitamins (thiamine, riboflavin, and niacin). It also contains important amounts of protein and iron. It is comforting in these "high cost of living" days to know the bread, enriched or whole grain, is a real prop for strained budgets.

As a nurse you know pretty well which foods are rich in certain nutrients. For your convenience we have listed them on the opposite page.

The list can be a useful basic tool for you to evaluate your own daily dietaries. Just for fun, add up the amounts of foods within each of the food groups you have had during the day. Have you eaten the recommended number of servings in each group? Then glance over the list of "Rich Food Sources of the Nutrients." Do the foods in your menus include those which are rich sources of several nutrients?

Remember to make your nutrition knowledge a personal asset. No matter how difficult —or how simple your living conditions may be—whether you go down a cafeteria line, cook on a one-burner gas stove, or eat at the Ritz—use your knowledge and imagination to choose meals that are well balanced nutritionally and good to eat, too. Health is the most valuable possession you have. Protect it by eating wisely.

PORTLAND PUTS IT OVER

HELEN NELSON

WOULD YOU LIKE to have all the health services of your city operating under one roof for a day? This was what the health division of the Council of Social Agencies in Portland, Maine, achieved with its second Community Health Fair. The result was an exciting day for Portland and a public relations feat well worth studying.

The idea for the first fair grew, as good community projects so often do, out of a public health nursing activity. When the board of the Portland District Nursing Association met early in the spring of 1946, to consider plans for a Public Health Nursing Week, it was only natural that Mrs. Benjamin H. Riggs, then president of the District Nursing Association, should suggest the fair as a means of showing how the Portland and South Portland District Nursing Associations work with other agencies to help keep everybody in Portland healthy.

Her suggestion was quickly adopted and from there on the entire project developed with speed and facility that reflected both the popularity of the idea itself and the efficiency of those who carried it through.

Thus a pattern was worked out in this first fair which was perfected in the second. Both times only one committee meeting was held. This was set for seven weeks before the big day—time enough to do a good job, but not enough to allow any lagging of enthusiasm.

Mrs. Nelson, NOPHS's *public relations consultant, went to Portland to see the Fair and to pick up the details of the preliminary planning from some of those who took part.*

This year the meeting was held on March 30, and the fair on May 17. At the meeting a general chairman and a publicity committee were named, and an overall plan and a working schedule adopted.

It was decided that a professional exhibit manager would be given responsibility for making uniform signs and for setting up the booths from material furnished him by the agencies. A charge of $20 for each booth took care of the manager's fee and miscellaneous expenses. No commercial exhibits were permitted.

Mrs. John C. Stevens II, president of the DNA, was made general chairman. To the publicity committee were named Mrs. Roger W. Hodgkins, publicity chairman of the health division of the Council of Social Agencies, Mrs. Dura S. Bradford, chairman of the public relations division of the Community Chest, and Calvin Eells, member of the editorial staff of the *Portland Evening Express.*

Probably the one factor which contributed most to the affair's success was the decision to urge the planning of "live" exhibits. Ninety percent of the individual exhibits this year consisted of either the actual carrying on, or the demonstrating of, a part of the agency's service.

It was decided also to build the 1949 fair around Child Health Day and stress wherever possible health services to children. So the city's schools were asked to provide an exhibit of posters and a continuous program throughout the afternoon. This, of course, helped draw parents.

Type of exhibits to be stressed, size of booth, personnel to serve, fee, and the need for immediate action were discussed in a letter sent on April 6 to all agencies and institutions it was thought might be interested.

As soon as an agency indicated it would take part, the chairman of the publicity committee, Mrs. Hodgkins, called its director or publicity director asking that material for a news release be sent as soon as possible. In order that these releases would have real news value, she asked not only what each exhibit would consist of, but what the agency would most like to tell the public about this service and its whole program. She asked for a picture of the service to be demonstrated.

THUS THE head of the orthopedic department of Maine General Hospital said he would be supremely happy if the hospital's exhibit could be used as an occasion to tell people in Anglo Saxon words what an orthopedist is. It took a lead paragraph announcing that arm, leg, and even fully body casts would be made for any youngster who wished one at the fair, plus a picture of a cast being applied, to get this definition in the body of the story, but it was done.

"Chest x-rays to be Available at Health Fair at Low Cost" heralded the announcement that the Cumberland County Public Health Department would give x-rays for 50 cents. (Such x-rays are always available at Portland hospitals for $1 upon appointment.)

Public health nursing is an educational and cumulative process, hence not easy to portray dramatically in 20-minute periods. The Portland District Nursing Association gave two demonstrations of the proper handling of a bed patient during the day and filled in with continuous films. Drama and headlines were gained by a mechanical heart, big as life and working away quite realistically with lungs, ribs, and diaphragm.

The South Portland District Nursing Association's exhibit depicted the setting for a well-baby clinic. It rated only a few paragraphs without a picture in the pre-fair announcements, but quick thinking on the spot netted a prize catch.

Early on the morning of the fair, one of the board members manning the exhibit stood gnashing her teeth as she watched a newspaper photographer roaming about looking for picture possibilities. All at once she spied a pretty miss in a beribboned spring bonnet coming through the door with her dolly, dressed in its very best, cradled proudly in her arms.

Quick as a flash she buttonholed the photographer. Dolly in the scales with her young "mother" looking on made a picture that stole Page One!

The publicity chairman had set as her goal that no resident of Portland would be able to pick up his morning and evening papers on any day for three weeks before the fair without finding at least one story about the coming event.

So exactly four weeks before she set about telling everybody how urgent it was to get material about their exhibit to her early. Despite her prodding only three agencies submitted complete material the first two weeks, and only four more during the third week. Most of the 26 exhibiting waited until the last week . . . and, of course some failed altogether.

Still, by means of several "overall" stories about the program and the number of agencies participating to date, and by filling in with photographs of the general chairman and the planning committee on the society page, editorials, and donated advertisements, Mrs. Hodgkins managed to better her goal.

The publicity chairman rewrote the material sent her in story form (double spaced and neatly typewritten), being careful to see that all the facts were there and all the names spelled right. She saw that the stories reached the newspaper office one at a time and never once complained because the story didn't appear just as she had written it or where she thought it should. She didn't have to worry about who should get the best stories, since both papers in Portland are published by the same company.

Altogether her scrapbook shows 5 feature articles, 32 news stories, 2 society articles, 2 editorials, and 7 advertisements.

All radio publicity was safely in the hands of Mrs. Dura Bradford, who, with considera-

ble professional radio experience, knew exactly what she wanted and got it. All four local stations were completely cooperative. Six one-minute spots and six breaks were prepared by Mrs. Bradford for each station. These were used constantly during the three days preceding the Fair. Fourteen interviews were also arranged and used on local women's programs, with members of the various agency staffs participating. All time was, of course, donated. The highlight was a singing commercial, again provided by Mrs. Bradford, and rendered amusingly at intervals by several announcers.

BUT WHAT were the actual accomplishments resulting from the good work and good publicity?

Some 8,000 Portland men, women, and children came to the auditorium of the city hall to view the fair. Youngsters were lined up four deep all day long waiting to get a cast put on their leg or arm which they might keep as a souvenir after it had been taken off later in the day. It is doubtful any of them will ever be quite as afraid of the hospital or the doctor's office again.

The auditorium balcony was filled all afternoon with an audience watching the program given by the physical education classes of the city schools. One woman was heard to remark, "Now maybe after Portland's shown them, Cape Elizabeth will be able to get physical education in her schools."

Ten patients were treated (as per appointment) at the city dental chinic's booth and the hundreds who stopped to look on were told by one of the nurses about the need for more facilities in order to take care of the more than a thousand on the clinic's waiting list.

The Portland Public Health Department gave smallpox vaccinations and diphtheria immunizations to more than 200 children. Only about half of these were scheduled, the others were brought by parents who had just stopped in. Two hundred and fifty persons were given chest x-rays.

The Junior League had a chance to explain to those who stopped by their booth why they were seeking funds to establish a convalescent home for children with rheumatic fever.

The nurses at the City Hospital, looking about for something to exhibit at the Fair, hit upon the idea of a "play cart" filled with toys especially selected to aid child patients in developing manual skills as well as to provide occupational therapy. The nurses are now using the cart every day at the hospital.

The Portland and South Portland Visiting Nurse Associations were able by this graphic presentation of the services they give, along with mention to interested bystanders of how much more could be done with more personnel and more funds, to gain community support for their long hoped-for combination of nursing services with the City Health Department.

These, of course, are only a few of the more tangible results. The enthusiasm engendered by people working together for something they believe in, the value of arousing the interest of a whole community in what their town is doing to help keep them healthy, are things which cannot be measured. Perhaps the best testimony to the day's success was the frequent comment:

"I wonder when we're going to have the next Fair?"

ROLE OF NATIONAL ORGANIZATIONS IN THE MIDCENTURY WHITE HOUSE CONFERENCE

Organization structure for the Midcentury White House Conference comprises the National Committee of 52 representative citizens, an Executive Committee, a working staff, four Technical Committees and four Advisory Councils, one of which is the Advisory Council on Participation of National Organizations. The functions of this council as approved by the National Committee are:

1. Stimulate national organization participation in policy and program determination.
2. Keep national organizations informed of policy and program decisions and developments in program and conference planning.
3. Make available to the National Committee the knowledge, experience, and resources of national organizations.
4. Stimulate the cooperation and participation of members of national organizations in communications, state and community action, fact finding, and the follow-up plans of the Conference.

"PLANTATION GRANNY": A NECESSITY

DEOLA F. LANGE, R.N.

IN LOUISIANA the plantation midwife continues to play importantly in rural community life. She is regarded as a counselor on family problems, a healer of all ills, a leader in civic affairs, a soothsayer, and a liaison between Negro families and the "Bossman." Above all else, she is the one person who can be depended upon when the expectant mother's time is nigh. Neither freezing weather, hurricanes, high water, nor torrid heat will prevent the granny woman from making her appearance when she gets the word.

While the health agency has certain regulations which must be met before a woman can practice midwifery, the plantation granny has her own reason for being called to service. This may be family tradition, her mother and grandmother before her having served many families. Or, as it frequently happens, it may have been the compliment of a very busy practitioner who told her that she should take up this work and that she had done a good job in helping him.

More usually, however, she has been "called." As one midwife said, she had seen a vision late one night, just as plain as day. An angel dressed all in white had taken her by the hand and had led her to a bed where a poor girl and her baby were in pain. The girl's hands were stretched above her head and she was pleading for someone to cut the navel string. She tried to forget this dream. She didn't want to do this kind of work, but she knew she must, and that same dream kept coming, coming, coming, 'til she made up her mind to go out and do the best she could with heaven to help her. These women feel that they should not fail when they "hear the call" for fear that they will be punished or a curse put upon them. With their deep religious convictions and their desire to serve, midwives are real personalities.

Mrs. Lange is a nurse-midwife on the staff of the Louisiana State Department of Health.

In picturesque Louisiana with its bayous, its towering oaks, its quaint customs, and its remote isolated areas, the plantation midwife still reigns supreme. Maternity patients, both Negro and white, with limited incomes, in areas far removed from hospitals, depend upon the untrained, kindhearted, and conscientious midwives, who despite superstition, ignorance, and advanced age, do the best they can.

Superstitious beliefs are very popular among the families served by the midwives, who themselves are in accord with these ideas and add some pet theories of their own. One hears a granny say she has steamed out the afterbirth by having a patient sit over a slop-jar of boiling water or smoking feathers. Sometimes she has administered green pecan and persimmon tea to stop the "hemmage" after the baby was born. On other occasions one may go into the home during delivery to find the midwife has placed the husband's hat on the patient's head and his pants under the pillow so that he can help the patient bear the pains. Placing an ax, knife, or other sharp instrument under the patient's bed to "cut" the pains is a popular belief, as is burying the placenta to prevent the dogs from getting it, which would surely cause the baby to grow up crazy.

Needless to say, the midwife, in sympathy as she is with these superstitions, is in excellent rapport with the patient. She listens and agrees with the patient's complaints, relieves the worry and anxiety of the patient and the family. Who is to say that the plantation midwife has not already contributed to childbirth without fear.

THE EDUCATIONAL status of the plantation midwife is deplorable, for the majority can neither read nor write and must depend upon friends, relatives, or members of the patient's family to fill out birth certificates. Unquestionably, this inability to read or write creates many problems. Recently, when a stillbirth certificate was received by a local health unit and the nurse questioned the midwife who had attended the mother as to the cause of death, it was learned that the infant was very much alive and kicking, the stillbirth certificate having been erroneously completed because the midwife could not read.

The average age of the Louisiana midwives is well past middle age, between 55-85 years. This is because rural people have more confidence in old midwives. These elderly women enjoy their prerogatives and discourage the use of young midwives. Further, the small fee paid for service does not attract younger women.

A familiar picture is that of an aged, decrepit Negro woman in a dark dress and white apron, with her head covered by a white headrag or scarf, smoking a pipe or holding a wad of snuff in her lip, walking along the road and being cordially greeted by those whom she takes pride in having brought into this world. One often hears the passerby's familiar greeting, "Good morning, Granny, how is you?" and the reply, "I'se feeling poorly, child."

Despite her many handicaps the midwife is a good source of referral to maternity conferences and private physicians. She has learned that antepartal patients applying to her for delivery fare best when medical care is given early in pregnancy by competent persons. Her case finding is not limited to maternity patients since she also assists by sending crippled children and well babies to child health conferences, and, by using her home as a center, she gathers the children in the community for immunizations against diphtheria, smallpox, and whooping cough. In these meetings it is not uncommon for the midwife to whisper to the nurse, "So and so who lives near me got a bad disease, or maybe it's consumption 'cause she sure is coughing."

THE PLANTATION midwife has long been recognized as a necessary compromise, but she presents many and varied problems to public health workers. In comparison with the national average income of $1141 per capita during the period from 1944 to 1946, Louisiana's per capita was the magnificent sum of $811. Even this low income is larger than many rural Negroes receive.

Not only are most rural Negroes hampered by inability to pay a physician, but in many instances medical services in rural areas are insufficient to provide physician's services for home deliveries. Home deliveries are a must,

because all too often private hospitals and sanatoriums in smaller places do not admit Negroes, the state general hospitals are too far away, and even those patients who manage to reach state hospitals are none too sure of admission because of inadequate facilities for Negro patients.

In 1945 the physician-patient ratio ranged from 743 inhabitants per doctor in one parish to 5,703 persons per doctor in another. Only four parishes met the standard of 1,500 or fewer persons per doctor. Louisiana has met this situation partly by broadening the education of public health nurses, who assume supervisory responsibility for the activities of plantation midwives, and appointing a nurse-midwife on a statewide basis to train and supervise the plantation midwives.

IN SO LARGE an area as the State of Louisiana, it is impossible for one nurse-midwife to assume complete responsibility for the direct teaching of the 1,200 or more plantation midwives. Therefore, much of the nurse-midwife's time is spent in teaching the technics of midwife supervision to public health nurses in the health units, so that they can carry on the program of midwife supervision in their own localities.

Upon visiting a parish, the nurse-midwife reviews with the nurses statistical data for the parish concerning the number of deliveries by midwives, live births, premature births, stillbirths, and infant deaths according to race, age, and cause. Following this, the nurse-midwife accompanies each of the local nurses in turn on home visits to midwives.

During the demonstration home visit, the nurse-midwife interviews the local midwife, seeking to learn the latter's attitude toward the health department, physicians in the community, the use of hospitals for the delivery of mothers, the registration of births, and the midwife's plans for patients whom she has been engaged to deliver.

Through discussion, the nurse-midwife also draws from the local midwife information concerning all of her activities and procedures step by step during a home delivery. As the interview progresses, information is elicited from the midwife regarding her own situation, that is, the sanitation in her home, living habits, religion, source of income other than from deliveries, participation in civic affairs, and sometimes the midwife's idea of the way she is regarded by people in the community. This latter may be revealed in the form of complaints about the few delivery calls she receives. Sometimes, on further exploring this cue, the midwife herself mentions the bad habits for which her neighbors criticize her and which cause their lack of confidence in her. During the home visit, the nurse-midwife examines the midwife's bag for completeness and cleanliness of equipment.

Immediately following the home visit, an evaluation conference between the nurse-midwife and the staff nurse is conducted, based on the information obtained from the midwife during the home visit. Together they discuss the weaknesses and strengths of the midwife, pertinent data to be recorded on the midwife's record, and the place of the midwife in the community. The aim of this conference is to give the staff nurse criteria for evaluating midwives in future visits which the nurse will make alone.

During the nurse-midwife's stay in a parish, she conducts one or more demonstration midwife meetings with the local nurses observing and participating. All nurses new in public health are oriented to the program of midwife supervision by participating in conferences between the nurse-midwife and staff nurses, as well as accompanying them on field visits.

A MIDWIFE meeting is quite an occasion. Everyone in the immediate community knows the day and place of the meeting. As one old granny put it, "You know, us takes lessons just like the doctors. If you need me, you'll know where to come."

The midwives bedeck themselves in white, and the aromas of Honeysuckle and Jockey Club perfumes permeate the air. Notices of the time and place of the meeting are sent out a week in advance. Most of the midwives arrive on time for the meeting. A few, however, get to the meeting several hours late with the usual excuses: the car broke down; the bus run late; I had to feed them chillun, them

hogs, and them chickens; my ole man is low sick; the Bossman brought me, and I had to wait for him; and many others. No matter how late a midwife is or how important the matters under discussion, she proceeds in greeting to kiss her very close colleagues.

The meeting opens with a song of many verses:

(Tune: *That Old Time Religion*)

Give me that new time midwife
Give me that new time midwife
Give me that new time midwife
She is good enough for me

She comes to all her meetings . . .

She uses plenty soap and water . . .

She is clean clean clean . . .

She knows them danger signals . . .

She sends me to the doctor . . .

She is kind when I am in Labor . . .

She knows when to call a doctor . . .

She registers all my babies
She registers all my babies
She registers all my babies
She is good enough for me

After the song one midwife prays. The usual prayer begins:

Oh, Lord, make us good midwives and bless us teacher;
Build her up where she is torn down, and prop her up on every leaning side;
Make her strong and take care of her when she is traveling these lonesome roads.

After the preliminaries, the nurse-midwife takes charge of the meeting, using the Midwife Manual as a guide. This manual consists of nine teaching units which constitute the training program for midwives. Each year these units are reviewed. The units are:

1. The Antepartal Period
2. Danger Signs and Symptoms of Pregnancy
3. Preparation for Confinement
4. Nutrition During Pregnancy
5. The Midwife's Standard Bag
6. Intrapartal Care
7. Care of the Newborn
8. Postpartal Care
9. Care of the Premature Baby

Because of their age and illiteracy many of the grannies forget easily, and constant repetition is essential with most of the teaching being done through demonstrations and return demonstrations by each midwife. Each study unit is covered slowly and simply at a separate meeting, although in some instances two or more meetings are necessary to cover a single unit. Among the demonstrations used in midwife meetings are: filling out

A midwife meeting is quite an occasion.

birth certificates; catching the baby; tying, cutting, and dressing the cord; exhibitions of locally grown foods, home made layettes, improvised baby beds; showing of films and posters on communicable disease, general health, and sanitation, and other visual aids such as the *Birth Atlas*.

Handwashing receives major consideration in each lesson with midwives. Individual basins and white towels are provided for each midwife and nurse. Hands are soaped, thoroughly rinsed, and dried. The towels are then hung before the midwives for them to judge by any dirty spots whether or not all hands were properly washed. An effort is made to prevent embarrassment of any individual. At one meeting, after these activities, a midwife pointed out her towel saying, "Nurse, this dirty towel is mine. From dust we come and to dust we will return—us is made out of dirt anyhow."

During the lesson on the midwife's bag, it is not uncommon to hear a midwife say, "Oh, Lordy! I done brought de wrong bag." We thus surmise that she has one bag for midwife meetings and another for use on deliveries. Her "Sunday" bag is usually a standard bag equipped year in and year out for the public health nurse's inspection. Her everyday bag ranges from a shopping bag to a pillow case and contains such articles as herbs, roots, spider webs, dirt daubers, quinine, vaseline, oil, powder, and other articles too numerous to mention.

SINCE THE Negro ministers have great influence with their rural followers, they have been drawn into the midwife program, not only to assist in the education of the midwife, but also as a means of securing publicity for the maternal and child health program. Special ministers' institutes are held to which all ministers in the parish are invited. The community midwives are also invited since they take great pride in going to a meeting with their pastor.

When the invitation is issued, the minister is given the topic of the institute and asked to be ready to discuss what he feels he can do to promote better health for mothers and babies.

A midwife demonstrates handwashing and shows the content of the midwife bag with explanations regarding the use of the various articles. The public health nurse discusses maternal and child health, venereal disease, and tuberculosis services available at the local health unit. The ministers are given a schedule of the clinics conducted by the department of health to use in referring patients.

These institutes create much enthusiasm. As one minister said to the midwife, "This was a great meeting, and that is as it should be—two important people together, minister and midwife. You administer the first service—bringing them into the world; we administer the last service, burial—taking them out of the world. So we should work together."

A NEW MIDWIFE is not permitted to work in a parish unless there is a definite community need for her services. If so, she is selected by the director of the health unit and the public health nurse. Very often her selection is at the request and recommendation of a retiring midwife. She must be in good health, not over 35 years old, able to fill out a birth certificate so that it can be read, interested in mothers and babies, a reputable member of a church, and in good standing with the people in the community.

After she is selected, she works for one year with another midwife who is selected by the department of health. She attends regularly all meetings for midwives held by the health unit.

According to the policy in Louisiana, midwives should retire when they have evidence of tuberculosis, when they have moderately severe symptoms of heart or kidney diseases, when they are feeble, when they show evidence of mental illness, when their vision is poor or beyond correction, and when their hearing is impaired to the extent that they cannot hear ordinary noises.

Recently the nurse-midwife approached one of the aged, mentally and physically feebled midwives relative to retiring. The midwife said, "Yes, nurse, I should put this work down—I is got the rheumatism, my legs can't get up when I sets down, and I can't see good as I used to—but I is on a mission.

I was called to do this work, and I'll have to wait—jest like I was showed when to start this 'bizness,' heaven will show me when to stop. You is talking 'bout man-made laws, but I is talking 'bout God's law—this is God's work."

Health department personnel can persuade, but there is no legislation which can force mentally and physically disabled midwives to discontinue their practice. One method used is to have them sign their names or make a cross on the following form which assumes an official appearance by being typed on the stationery of the State Department of Health:

Date———

IN APPRECIATION FOR SERVICES RENDERED

This is to certify that ———— is retiring from the practice of Midwifery because of her poor physical condition and her advanced age. She is now receiving old age assistance and not dependent on Midwifery for a living. ———— has worked hard and faithfully and is to be highly commended for her long years of service. The Health Unit appreciates all she has done to better the health of mothers and babies in her community, and it is felt that she will continue to help in as many ways as possible.

Director, ———— Parish Health Unit

Staff Nurse

Witness

I, ————
declare from now on that I will not deliver any more mothers.

Midwife

Date ————

PUBLIC HEALTH workers unanimously agree that the midwife problem in Louisiana is an acute one; that its solution demands more and better medical facilities available to all people in the state, community education on a statewide level, and continuous teamwork on the part of all concerned. We in Louisiana are not complacently waiting for one of the midwives' miracles to be performed or for a vision in the night to solve the problems. Instead, concerted efforts of the health department personnel are slowly, but surely, bringing about desirable changes on the part of the illiterate midwives in particular and the rural communities generally. A few of the many activities which are in operation to make all persons cognizant of the problem are:

1. The monthly instructional classes for the plantation midwives conducted by the public health nurses.

2. Supervision on the job of midwives by the nurse-midwife as a means of correlating theory with practice.

3. Ministers' institutes as a means of education and giving publicity to the maternal and child health program. The ministers have tremendous influence in rural communities.

4. Seminars conducted by the nurse-midwife with the local medical society on the midwife problem in the particular locality.

5. Participation in the in-service rural teacher education workshops by the nurse-midwife as a means of interpreting the midwife situation and the schools' place in the total program.

6. Participation in community programs: parish fairs, state and local PTA programs, festivals, and other activities by the nurse-midwife. Short talks, demonstrations, and visual-aid materials are made available on the maternal and child health program throughout the state.

The midwife situation in Louisiana is clearly defined. Its solution is not yet a certainty. The Children's Bureau, the state and local health units, and the Public Health Service have been and are contributing financial support, personnel, and effort to improve and abolish this compromise. However, with 9,485 deliveries by midwives during the year of 1948, with approximately 1,200 plantation midwives practicing in the State of Louisiana, with the infant mortality rate 38.1 per 1,000 live births in Louisiana in 1948 and the maternal mortality rate 1.6 (non-white 2.5) during the same period, it is agreed that more nurse-midwives, more physicians, more public health nurses, and more hospitals and clinics strategically located will be necessary to supplant and abolish the "plantation midwife —the necessary compromise of public health in Louisiana."

GETTING A RURAL SCHOOL HEALTH JOB DONE

ANNE B. STEED, R.N.

IT WAS GRAND to be called County School Health Supervisor but I was the only nurse in the county program. In addition to the administrative duties of the position, I served as staff nurse. My prime thought was, "How could one nurse possibly carry out in eleven rural schools, with between 5,000 and 6,000 children, any kind of a good health program?" Actually all of my time could be used in going from one school to another, taking care of the routine needs of the principals, teachers, and children. And I saw that somehow we had to inaugurate new and important activities in these schools.

After a little hard thought I came to the conclusion that with the understanding assistance of teachers and students a more complete health program might be carried out and at the same time the students stimulated to a new interest in health. My plan was to interest the students in taking an active part. The familiar adage, "We learn by doing", would be the key to the problem. I thought our school health program would be much more meaningful if the students really took part in each program we planned. And much more could be accomplished in the entire county if students in each school could be taught to carry out many of the procedures which did not necessarily have to be done by the nurse.

Next step was to suggest in each of my eleven schools the idea of a student health council.

Success depended first of all on the cooperation of the teachers. In fact the teacher is the central figure in the success of any total school health program. Day by day she can give her students a broad background of knowledge of the principles upon which healthful living is based. She can help them develop the attitudes, skills, and habits essential to living healthfully. In a rural area, where the nurse's time in each school is limited, the teacher has the greater opportunity to guide the students in carrying on throughout the year with their health programs.

My approach was to the principals and through them to each individual teacher. In one of our larger schools, the physical education teacher was in charge of the health work. This teacher was keenly interested in the idea of a student health council and amenable to suggestions from the nurse in the development of the program. He soon had a council which was really working. It was started out of his senior health classes, by dividing the classes into committees of three or four to assist in such programs as immunizations, physical examinations, dental examinations, hearing tests, vision tests, general health, preschool clinics, the posters on safety and health, and the milk program. The milk program was handled by the student committee and through it milk was supplied to children in the first three grades at 10 o'clock in the morning. The health council met once a month to discuss current problems and hear the reports of the various committee activities. The teacher, who was responsible for the council, felt that

Mrs. Steed was, at the time of promoting the Student Health Council program she describes, county school health supervisor in Delaware County, Indiana. She is now doing school nursing in Dearborn, Michigan.

it worked most effectively—the students learning through actual practice and assuming a load ordinarily carried by the teacher or else left undone.

In each of the other schools, although not having as well developed a student health group as the one described, they organized a health committee assigned to assist the nurse on each special program which was carried on in the schools. The teachers themselves were interested and eager for what help the nurse could give them in the guidance of students. With their increasing experience the teachers will eventually become responsible for an educational program of positive health in the schools.

HERE ARE SOME of the details of the organization of student help in this county. Let's start with the immunization program. It would have been impossible for one nurse to carry out the program on a countywide basis,—assist the doctor, keep the records of what was being done, and answer the many questions of each parent, teacher, and child at the time of immunization—and at the same time economize on the doctor's valuable time in the school. Prior to immunization day, plans were made to talk with groups of girls who were interested in going into nurse's training and groups of boys who thought they might like the medical field, with the idea of assigning selected individuals to help the nurse. On immunization day, before the doctor arrived, I talked with the ones chosen, explaining the importance of each of their duties. The students rounded up the children, cleaned the area for injection on the arm of the child in preparation for immunization or vaccination by the doctor, and reported the data on each child immunized. After the doctor left, I discussed with the group what they had done, answered their questions, and demonstrated to them how they could prepare for my next visit to the school.

As regards the confidential basis of the health records. The records are kept filed, by the individual classroom teachers in the elementary grades and in the principal's office for the secondary grades. In some instances the information about the pupils was charted by the teachers. In each school, there were never more than two and usually only one senior student assigned to chart any defects. These same students assisted with the recording of data for all examinations done in their school. In the case of any added important problem, I would do the charting myself. The data charted by the one or two students in each school assigned to record were really not of a strictly confidential nature, such as normal vision and hearing scores, heights, weights, immunizations or vaccinations, and the like. The abnormalities and other information which were of a confidential nature were charted by the nurse and discussed with the teacher.

On the last immunization and smallpox vaccination visit, I called my group of assistants together and explained to them the value of permanent records and follow up. Later, this was discussed with the particular teacher who kept the child's permanent record card. A list of tasks performed was sent to me from the student health assistants in each school and a copy of the permanent record card was sent home to the parent of every child immunized or vaccinated, stating the type of toxoid the child received and the date the immunization was completed. The completion of this record work was the responsibility of the student assistants and they seemed to enjoy doing it. Their help gave me valuable extra time for other important duties. The teachers too, began to show a growing interest in the children's health records as they realized the meaning and usability of the records.

THE COMPLETION of our physical examinations in each county school was also made possible through the fine assistance of the student health groups assigned to work with the doctor and the nurse. Five or six students were selected to help with the physicals in each school. I worked with the students preceding the examinations, showing how to weigh, measure, take temperatures, and record. The students would have the set-up ready for the examination the morning that the doctor and the nurse were scheduled to arrive. In all of the elementary grades the

teachers were encouraged to be present for the examination. During the physical examination, printed forms were filled out by the student assistant and any defects found were charted. I checked each slip after which copies of the reports were sent to the parents of all children who had received an examination. I charted the results on the school's permanent record card for the child and discussed them with the child's teacher.

All of the records were reviewed at frequent intervals during the year by the teachers. As the recording was being done, I was always present to guide the students and to check on their work. Looking back on our program I believe we had very few errors in recording. This, I feel, was due to the careful selection of the students picked to do the recording and to the preparation which he or she was given for the work.

In our preschool examinations in the spring, the student group, who by this time were quite familiar with their duties and responsibilities, helped make our clinics more successful than they had ever been. In addition to taking temperatures, weighing and measuring, assisting the doctor and recording, two students were taught how to use the Snellen Chart for Vision Testing. Both our little preschoolers and the older students who did the testing seemed to enjoy thoroughly their little game of telling "which way the legs of the table point?" The preschool clinics were organized in most of the schools by the first grade teachers who were assisted by active and interested parents.

THE VISION testing program in some of the schools was turned over to the group of student health assistants, who, with the teachers, did the complete screening of the children with the Snellen Chart. These same students then assisted me when I rechecked the children who required it with the Massachusetts Vision Testing Machine. Through this experience, the students learned many things both about the importance of maintaining normal vision and the effects of uncorrected visual defects on a child's learning capacities and progress in school. Some of these young people became interested in good lighting and ways by which they might help secure and maintain a better lighting system for their school. The results of the vision testing were always discussed with each teacher and oftentimes helped explain individual learning problems due to visual defects.

Another project in which every student health group took part was the survey following up the dental examinations which were done in the county the preceding spring. By this means we were able to obtain the percentage of students who had had the recommended dental corrections made. The survey, too, encouraged a great many who had not seen their dentist to go immediately. It was found that about 40 percent of those with dental defects sought corrections and this information was then presented to our local dental society. We then started on a more thorough dental examination of the children in the grades—1st, 4th, 7th, and 10th. The student health group were taught how best to assist the dentists in their work, mainly by keeping their instruments sterilized and by recording the defects found. Others in the student health group were in charge of distributing literature and rounding up those children who were to have the examination. Some of the literature was used by the teacher in a telling way in her classroom discussion on dental health.

THROUGH their splendid assistance, these boys and girls on our school health committees not only made it possible for us to broaden our total health program in the county but the program itself became an educational experience to the boys and girls. Through their active participation in some of the procedures, I am sure, even though I spent a few extra hours getting the student help started, it was well worth the time. It resulted in these helpers learning about themselves and developing a keen interest in the entire community school health program. To the teachers, the student health councils showed a means of learning through actual practice. And they were relieved of certain detailed work which they felt important but had left undone because of their heavy schedules. The teachers found most helpful the

information given them regarding the findings of the school health examinations as they were able to obtain a clearer picture of individual pupil problems and were therefore better able to understand and help these children.

As our total field of public health is moving forward by leaps and bounds, perhaps in the not too distant future, we will see "health" incorporated into the total school program as an integral part of every subject taught. Then the nurse's duties in school will be mainly those of supervisor and consultant in health education. This change in the curriculum in many of our schools will not arrive overnight. As with all changes, especially in a rural community, it takes time, understanding, and preparation of those whose duty it is to teach.

During this period of transition, why not try a "student health council" in your school? Even if you are one of the many nurses who are faced with the daily challenge of deciding what to do on your list of important things to be done and what not to do because of lack of time and help, I am sure that you will find the effort you may spend to organize your student health groups most profitable. You will soon discover that you are able to accomplish more. Even more important, you will find the students learning their own health needs through the active part they play in the student health councils. Let us remember, however, that the teacher will always play a large part in the health education of her pupils and she is in the best position to guide any health program throughout the year. For our greatest success, we must work with our teachers and through them with our student health assistants. In the final analysis, one of the objectives in public health nursing is to have our teachers and students take over the responsibility for their own "Healthful Living."

DAYS AND HOURS OF WORK, 1946 AND 1948

DOROTHY E. WIESNER AND SYLVIA WEISSMAN
NOPHN Statistical Department

THE MOST outstanding change in days of work per week appears among the non-official agencies. In 1946, only 9 percent of the Yearly Review sample reported a 5-day week, whereas 43 percent reported a 5-day week in 1948. In city health departments, 16 percent reported a 5-day week in 1946, and 34 percent in 1948. In county health departments, the increase was less marked: 11 percent reported a 5-day week in 1946, and only 14 percent in 1948. In boards of education, the 5-day week has been more usual for many years; 82 percent reported the 5-day week in 1946, and 89 percent in 1948. (See Table 1.)

Even though the figures are small, another interesting comparison, particularly among county health departments, is in the reporting of a 5½-day week once or twice a month with the other weeks being 5-day weeks. Only 2 county health departments reported this kind of week in 1946, as compared with 17 in 1948. Among the other replies about work weeks were the following: 4 full days and 2 half-days a week; mention of nights and weekends on call; variations in one agency, according

TABLE 1. COMPARISON OF DAYS OF WORK PER WEEK FOR 1948 AND 1946 BY TYPE OF AGENCY

Type of agency	Total agencies		5-day week		5½-day week		5½-day week once or twice a month otherwise a 5-day week		Other reply		Not stated	
	No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent	No.	Per-cent
Nonofficial												
1948	251	100.0	109	43.4	115	45.8	16	6.4	11	4.4	.....	.....
1946	147	100.0	13	8.8	119	81.0	6	4.1	8	5.4	1	0.7
City health departments												
1948	100	100.0	34	34.0	49	49.0	13	13.0	3	3.0	1	1.0
1946	58	100.0	9	15.5	42	72.4	6	10.4	1	1.7	.....	.....
County health departments												
1948	135	100.0	19	14.1	96	71.1	17	12.6	2	1.5	1	0.7
1946	64	100.0	7	10.9	54	84.4	2	3.1	1	1.6	.....	.....
Boards of education												
1948	168	100.0	149	88.7	16	9.5	2	1.2	1	0.6	.....	.....
1946	91	100.0	75	82.4	13	14.3	1	1.1	....	.....	2	2.2

to the week of the month, of a 5-day week, a 5½-day week, and a 6-day week. Only 2 of the 654 agencies reported a 6-day week in 1948.

So far as number of weekly work hours is concerned, a work week of 41 hours or less was reported in 1948 by at least 80 percent in each of the four kinds of agencies. The decrease in the percent reporting 42 hours and more is most marked in the nonofficial agencies. The percent reporting 40-41 hours (for the most part 40 hours) was higher in 1948 than in 1946, in all but county health departments. Another comparison of interest is that only 22 percent of the nonofficial agencies reported a work week of less than 40 hours in 1948, whereas more than 50 percent of the other three types reported this shorter work week. Table 2 shows these comparisons of weekly work hours in detail.

TABLE 2. COMPARISON OF WEEKLY WORK HOURS FOR 1948 AND 1946 BY TYPE OF AGENCY

Type of agency	Total in sample		Less than 40 hours per week		40-41 hours per week		42 hours and more		Not stated
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	
Nonofficial									
1948	251	100.0	54	21.6	156	62.1	37	14.7	4
1946	147	100.0	21	14.3	76	51.7	47	32.0	3
City health departments									
1948	100	100.0	56	56.0	31	31.0	10	10.0	3
1946	58	100.0	31	53.5	15	25.9	11	18.9	1
County health departments									
1948	135	100.0	70	51.9	38	28.1	25	18.5	2
1946	64	100.0	30	46.9	20	31.2	14	21.9	....
Boards of education									
1948	168	100.0	116	69.0	40	23.8	11	6.6	1
1946	91	100.0	62	68.1	15	16.5	9	9.9	5

TRENDS IN MEDICINE AND PUBLIC HEALTH

NATURAL CHILDBIRTH

Physiological or natural childbirth occurs when the structure and function of each organ taking part in parturition are not impaired by any chemical, emotional, or mechanical anomaly. There is no physiological evidence that childbirth should be painful or that pain serves a useful purpose in labor. Dr. Grantly Dick Read believes it is possible to remove fear and tension during labor and induce a state of mind which is understanding and serene, a state of body which is physically fit and muscularly relaxed and controlled. (April 30, 1949 *Lancet*.)

At Maternity Hospital, Woking, England, Dr. Read analyzed 516 maternity cases in an effort to draw attention to the application of his teaching. A great many of the women participating had come to the clinic because of an exaggerated fear, either inherent or engendered by previous labors. They were given antenatal instruction in simple physical exercises—relaxation and respiration—and in the elementary phenomena of pregnancy and parturition. The main principles adopted were to avoid interference, pain, and any horror of childbirth. Safety of the mind and body of the mother and health of the baby were embodied in these objectives.

The 516 cases comprised: 429 physiological deliveries, 52 forceps, 28 caesarian sections, as well as 7 pairs of twins which are not included in the study. There were no maternal deaths.

In the administration of sedatives, analgesics, and anesthetics, 239 mothers had no drug whatsoever, 47 had chloral and bromide only, and 23 had barbiturates only, these being given to induce sleep in early labor at night. None of these 309 mothers needed any pain-relieving measures. Morphine or pethidine, with or without chloral and bromide, was given to 87 mothers because of distress at the first or second menace. Dr. Dick Read states, "A labour is made or marred by the care and management of the first emotional menace which occurs when the cervix is $\frac{3}{5}$ dilated." A self-administered analgesic, with or without a sedative, was taken by 34 mothers, and a few whiffs of chloroform were given to 3, either at the transition from first to second stage or at the early crowning of the head. At the latter point all women were offered gas but few accepted if the transient nature of the discomfort was explained. A general anesthetic plus sedation was given to 48 for application of forceps.

Cooperation in labor usually depended on antenatal preparation (1) education in and understanding of the processes of pregnancy and labor (2) ability to relax during first-stage contractions and between second-stage contractions and (3) physical preparation by a few simple exercises designed to give full, free, and controlled respiratory movements, mobility of pelvic joints, and general muscular fitness. Three hundred seventy-five cooperated well, refusing analgesia.

Dr. Read's conclusions, based on the 516 cases are as follows:

Childbirth is a physiological function, not a pathological state. It is the serious test of a woman's fitness for motherhood which is of biological and sociological significance. Most women who are taught how, and assisted, to perform this natural test neither need nor desire drugs or anesthetics.

The integrity of the physical mechanism of eutocia varies as the integrity of the emotional phenomena. The emotion of fear increases tension, disturbs stimulus interpretation, and so causes pain in otherwise normal labor. The understanding and care of the emotions avoid pain in labor and so protect both mother and child from dangers associated with interference.

The length of all stages of labor in this series is considerably shorter than the average given by Dr. Lee (1938).

A conscious and controlled woman can assist in preserving the perineum from serious injury.

Fondling and suckling of a baby by the mother immediately after its birth, combined with a rational conduct of the third stage of labor, minimizes the loss of blood, and the mothers get up on the third or fourth day after labor.

Sedatives and analgesics should be freely offered for emotional or physical disturbances during labor, but never given against the wish of the woman.

The "effort syndrome" is commonly mistaken for pain.

The antenatal diet of women of all classes should be a subject of instruction and serious advice.

No woman can cooperate in labor if she is left alone to "get on with it."

Practically all women having physiological labor wish to breast-feed their babies and do so successfully.

A rapid recovery to birth weight is not an indication of the ultimate well-being of a baby. Many slow starters make normal progress after the mother leaves hospital and ceases to worry about home affairs.

The outstanding impression gained from the women in this series is the absence of all aversion to parturition. They speak of the supreme happiness of childbirth. Their euphoria is without design. They desire to repeat the experience as soon as the economic and domestic difficulties of our present social disorganization make possible the housing and upbringing of another child.

Finally, it has become apparent that the woman of today demands to be taught how to have a healthy baby in a healthy way. She wishes to collaborate so far as possible in this achievement.

EAT A GOOD BREAKFAST

Six healthy normal women 22 to 27 years of age were the subjects of a recent experiment designed to show the relationship of good and poor breakfasts to (1) maximum work output (2) simple and choice reaction time and (3) neuromuscular tremor. Results were published in the February 1949 *Journal of Applied Physiology* by W. W. Tuttle, Marjorie Wilson, and Kate Daum.

The women were tested under conditions of a heavy breakfast (800 calories), a light breakfast (400 calories), no breakfast, and a single cup of coffee, cream but no sugar. There were three 3-week periods to each experiment, actual testing taking place twice a week between 11:00 a.m. and 12 noon.

At the end of the experiment, it was possible to draw these conclusions:

The omission of breakfast caused a decrease in maximum work output, an increase both in simple and choice reaction time, and an increase in tremor magnitude.

When coffee alone is substituted for a heavy breakfast there is a decrease in the level of performance in maximum work output and choice reaction time; an increase in tremor magnitude.

When a light breakfast is substituted for coffee alone the level of performance of maximum work output and choice reaction time improves significantly; there is a decrease in tremor magnitude.

Considerable individual differences appeared in response to altered breakfast habits.

Because the breakfast period of coffee only occurred between heavy breakfast and the light breakfast periods a direct comparison of the physiologic responses during the light and heavy breakfast periods could not be made.

Concrete suggestions for good breakfasts for persons of various ages and types are given in a handy little leaflet published by the Cereal Institute, "A Basic Breakfast Pattern." Write to the Institute at 135 South La Salle Street, Chicago 3, Ill.

CASE-FINDING CAMPAIGN FOR SYPHILIS

Twenty-seven states and the District of Columbia with a population of 96,500,000 people cooperated this summer in the renewed drive to wipe out syphilis. In over 200 communities, the official health agencies, voluntary groups, medical societies, and other organizations joined with the Federal Government

in the effort to find the one million people who "have syphilis and don't know it." The month of June was devoted to groundwork, July and August to discovering and treating every case of syphilis in the participating areas. The campaigns were conducted along the lines of the "pilot studies" held in Washington and New York City in 1948. It is hoped that the success of some communities will inspire others until there is welded together an unbroken chain of states, cities and towns dedicated to the elimination of syphilis as a leading cause of sickness and disability.

Columbia University has set up a Communication Materials Center to provide, on a nonprofit basis, public appeal materials for the use of state and local health departments and other public service agencies. This past summer the concentration was on the production of materials for VD case-finding drives, —radio transcriptions, movies, leaflets, and other published materials.

SMALLPOX VACCINATIONS IN PREGNANCY

A report of a study to determine the effect of smallpox vaccination on the outcome of pregnancy by Bellows, Hyman, and Merritt was published in the March 11, 1949 *Public Health Reports*.

A total of 893 pregnant women was observed, of whom 720 were vaccinated and 173 were not. On the basis of the evidence presented in this study, it is concluded that smallpox vaccination during pregnancy does not increase the incidence of congenital malformations, stillbirths, abortions, or of infant deaths.

THE STUTTERING "HABIT"

Probably no other common disorder has received as little attention from the medical profession as stuttering, although nonmedical specialists have published more than 200 experimental studies on its various aspects. *Pediatrics*, August 1949, offers a summarization and interpretation of some of those studies dealing primarily with the "beginning" stutterers.

Out of studies and therapeutic tests already completed, a new theory of stuttering has been developed by Wendell Johnson, director of the University of Iowa Speech Clinic. The theory holds that the most common and significant cause of stuttering is in the diagnosis itself. Research has shown that speech repetition is normally found in the speech of preschool children. When a parent becomes aware of this occasionally repetitive speech, he assumes it is abnormal. Such misevaluation leads to unwarranted concern and expressions of parental disapproval. In a vain effort to eliminate this nonfluency, the child develops tension which in turn increases the frequency and duration of the moments of repetitious speech, forming a vicious circle.

The first essential in the "treatment" is a detailed history of the stuttering. In the first counseling session following the history and examinations is a discussion of the theory of stuttering with the parents. Care is taken to allay any parental guilt reactions. This "therapy for parents" takes the form of education as to the realistic standards for speech of preschool children and of reassurances as to essential normality of their own child's speech. It is not desired that parents forget the stutterings, but that they learn to evaluate these interruptions properly. The goal of speech correction can only be approached gradually and indirectly. It should be emphasized that this therapy is designed for children who have not developed anxieties concerning their moments of nonfluency and marked muscular tensions during those moments. Children who have become confirmed stutterers may benefit from improving the psychologic environment and elimination of expressions of parental disapproval, but they almost invariably need additional treatment from a speech correctionist.

Drug therapy is strictly contraindicated. It tends to reinforce the parents' feeling that something is seriously wrong with their child. None of the drugs has any rational basis or any adequate proof of clinical effectiveness.

ELECTROSHOCK IN PSYCHOSES

At the time of the annual session of the American Psychiatric Association, according to an editorial in the *Journal of the American Medical Association*, August 6, 1949, an of-

ficial statement on the use of electroshock was issued by the president, Dr. William C. Menninger, and by Dr. Nathan K. Rickles, president of the Electroshock Research Association. The statement follows:

Electroshock therapy is accepted today as the most effective physical agent in the successful treatment of the majority of the affective psychoses when given by properly qualified psychiatrists.

It should be stressed that at no time is electroshock advanced as a cure-all, but as one very effective agent in selected classes of mental illness. It should always be preceded by a complete and thorough psychiatric study of the patient which includes an evaluation of his mental and physical status, his family and his environment, and also be followed with adequate psycho-social study and psychotherapeutic guidance.

This decision should be known particularly to general practitioners, since at least two thirds of acute psychoses are first seen by general practitioners.

RURAL AMERICA

THE EMERGENCY situations, brought out by the severe winter storms of 1949, emphasized the fact that excitement and suspense are often part of the routine of public health nursing.

Mrs. B. worked as a rural school teacher until her seventh month of pregnancy. She intended to go to a Montana hospital for delivery. When she felt unwell, she asked the school board for a week's leave and started for Baker, Montana, about 55 miles away. The roads became blocked as a storm came on but she succeeded in walking to a nearby country home where three rooms were already crowded with eight regular inhabitants. However, the housewife took her in. The farmer walked three miles through the storm to the nearest telephone to call the doctor. The physician went out by plane to find that the patient had already been delivered, in a situation which was in every respect objectionable for a delivery. Since the patient was out of her own home and had suffered undue exposure before delivery, prophylaxis of penicillin and close observation were ordered for both mother and child.

The public health nurse flew in, as soon as the pilot could safely land, with perineal dressings, medicines, food for the baby, and general provisions. She returned for three successive visits to give penicillin to the mother and eye prophylaxis to the baby. The 4½ pound infant did very well in a home-made basket heated with hot water bottles. It became rather jaundiced by the fifth day, but took liquid more freely thereafter and seemed to improve.

When the baby was three weeks old the mother returned to teaching, leaving the baby in the care of a neighboring family. By this time the child weighed 5 pounds and was doing nicely.

Mrs. C. was a pernicious anemia patient who had developed a serious infection in the right foot. The family lived in a small community 30 miles from headquarters. Since Red Cross emergency workers were going into the locality on survey purposes, the nurse was asked to visit this family and arrange for whatever care was necessary. The pilot met extremely bad weather, nearly made a crash landing, and returned to his home at Bowman. The following day one of the army men working on snowbound roads offered to drive the nurse into the area behind the bulldozers breaking a track. This trip was successful and arrangements were made to have the patient taken to a hospital. The pilots, trained during the last war, made the emergency flight, and the local Red Cross Chapter met the necessary expenses incurred.

At all times the public health nurse acted under the orders of the physician in charge.

MRS. MARGARET PATCH, R.N.
PUBLIC HEALTH NURSE, SLOPE AND BOWMAN COUNTIES, NORTH DAKOTA

NEW BOOKS
AND OTHER PUBLICATIONS

TEACHER'S GUIDE FOR HEALTH EDUCATION

By Morey R. Fields and Avis E. Edgerton. New York, Remsen Press, 1949. 543 p. $5.00.

It is a privilege to review a book such as this. It is a valuable tool and flexible guide for the elementary grade teacher, junior high teacher, the school administrator, and the health leaders interested in aiding the classroom teacher. Moreover, this text is invaluable in the training of teachers through their college classes. The knowledges, understandings, attitudes, and appreciations which are emphasized give practical help, suggestions and ideas which the creative teacher can use increasingly in her work. The page referencing of the several Health Series on each grade level is a great saving of time for the busy teacher. It is not only valuable to the teacher but also to the hundreds of children who sit in classes day by day where they are being taught to organize committees, bring back their information for group discussion, and use their findings as a part of their daily living.

The authors recognize and stress the significance of motivation in all teaching but especially in teaching healthful living. Constructive health growth and development are emphasized rather than defects and diseases; ways of living healthfully and solving problems, as they arise, are continuously brought to the attention of the reader; recognition of the needs of the child to establish health habits and information necessary to meet his problems, make decisions and practice healthful habits is clearly given.

The content and the format of the book make it of value to the teacher in preliminary planning for developmental lessons in health teaching. The specific grade levels are clearly given and include (1) goal of students (2) procedure and method (3) materials including bibliography for teacher and pupil and (4) desirable outcomes, which may be checked with goals.

The authors of this practical book have made a real contribution to the teaching of health through our schools.

—Alice Shine Coogan, R.N., *Nurse-Teacher, East School, Neptune Boulevard, Long Beach, N. Y.*

EVERYDAY PSYCHIATRY

By John D. Campbell. 2nd. ed. Philadelphia, J. B. Lippincott, 1949. 394 p. $6.00.

To a psychiatrist of psychoanalytic training and practice this book comes as a shocking reminder of the sterile unproductive brand of psychiatry seen in old text books. His concept of conscience, for example, which he defines (page 194) as "an innate constitutional personality trait that like intelligence is a faculty which can not be improved upon by either education or training" is like an echo of the old descriptive constitutional (and institutional) psychiatry.

Although he professes an ecliptic point of view, his references to etiology of the functional personality disorders consist essentially of a brief debate between hypothetic proponents of "constitutional psychiatry and psychoanalysis." There is not even a single chapter devoted to the important recent advance in Psychosomatic Medicine.

Like many psychiatrists of the old school who have not taken the trouble to keep abreast of new developments, the author fumbles awkwardly with psychoanalytic concepts and ideas which he finds confusing and with which he confuses the reader. The best part of the book consists of the author's collection of interesting case histories and colorful personality studies which Doctor Campbell portrays with considerable descriptive talent.

—Morris C. Beckwitt, *M.D., Psychiatrist, Lecturer in Psychiatry, Wayne University, College of Nursing, Detroit, Michigan.*

ADOLESCENCE PROBLEMS

By William S. Sadler. St. Louis, C. V. Mosby, 1948. 466 p. $4.75.

This book meets a well defined need for the study of this problem, the adolescent age. It is written from a modern point of view. It is very readable as a book and holds the reader's interest and attention to the conclusion.

The division of the material in six sections is of special value. It is because of this division that it is easy for the reader to find ideas on the particular phase of the topic with which he is concerned at the moment. This book would be valuable to the junior high and senior high teacher for use as a refresher course on this topic. In fact, it is a needed book for all teachers.

This book will appeal to the reader as a stimulant toward further study. It is well printed and has an excellent reference list. It is packed with usable information. It should prove of value to the groups which the author wishes to reach—the physician, the parent, and the teacher.

—Marguerite Holman, *M.D., Supervisor of Health, Jamestown Public Schools, Jamestown, N. Y.*

INTRODUCTION TO HUMAN ANATOMY

By Carl C. Francis. St. Louis, C. V. Mosby, 1949. 470 p. $5.50.

The author's aim "to present the essential facts of anatomy in the smallest possible compass" has been fulfilled by thoughtful selection of material and excellent plates. The photographs of joint motion are particularly helpful. The material is organized from a functional point of view, but this reviewer would have liked to see this idea developed more fully since presumably the text was intended to aid the instructor who is teaching student nurses. For example, the description of the skeleton and muscular systems could be made more meaningful if the instructor had given additional facts regarding the relation of structure to normal activity.

The teaching of anatomy to nurses has not in the past succeeded in providing a real working knowledge of the subject primarily because little opportunity is provided to put this knowledge to use. The author has made some laudable efforts in this direction and the text should be a good reference for the student. The instructor will need to supplement it with more material in order to coordinate the subject with physiology and pathology.

—Doris Langdon, *R.N., Public Health Nursing Consultant, Division of Crippled Children, State Department of Health, Hartford, Connecticut.*

TEXTBOOK FOR ALMONERS

By Dorothy Manchee. Baltimore, Williams & Wilkins, 1947. 466 p. $7.50.

This is an excellent reference for the student and working almoner. It is written by an almoner in an English hospital and describes the development of the work of almoners, which corresponds to the work of medical social workers in American hospitals. As much of the book refers to specific legislation in the British Isles with particular reference to the English financial setup in agencies and hospitals, it would probably have little interest as a textbook for Americans. It is valuable as a reference book, however. There is a section devoted to the social aspects of disease, which is a simple and basic presentation of data referring to various kinds of diseases—symptoms, causes, care, treatment, special developments to be observed, and the like. It does not go into the psychosomatic phases of diseases, but treats mainly the role of the almoner in the handling of attitudes of patients toward the diseases.

—Gordon H. Barker, *Ass't. Professor of Sociology, Chairman of Department of Social Sciences, University of Colorado.*

A MANUAL FOR BABY SITTERS

By Marion Lowndes. Boston, Little, Brown and Company, 1949. 168 p. $2.00.

Baby sitting has become an important function in our modern culture. This little book attempts to place it in the professional class where it so rightfully belongs, with rules and regulations applicable to both sitter and parent.

On an excellent foreword, Gladys Romanoff, director, Kips Bay-Yorkville Course for Baby

Sitters, states that the fundamental qualification for this new business which, incidentally is Big Business, is love of babies. That is the book's major premise and "Keep them happy, Keep them safe" its slogan.

The twelve essentials for baby sitting are explicitly stated. There is a treasury of games—indoor and outdoor, a list of books to be read aloud. There are suggested menus with simple instructions for their preparation. There are admonitions about accidents and instructions for care of emergency illnesses. There is a reference list that should be required reading. Throughout the psychology is sound.

Mrs. Lowndes' very practical book is a must for sitters whatever their age or experience and for parents who entrust their children to the care of "The Sitter."

—Mrs. Mary Smith Campbell, *40 Bauer Terrace, Elizabeth 3, N. J.*

PRINCIPLES OF PSYCHIATRIC NURSING

By Madelene Elliott Ingram, 3rd edition. Philadelphia, W. B. Saunders, 1949. 525 p. $3.75.

In this revision the general approach to psychiatric nursing remains essentially the same as in the 1944 edition, although in the preface the author directs attention to socio-psychosomatic medicine. The material is presented in a simple, usually direct, and interesting manner, and the textbook has greater visual appeal than the previous volume.

Minor changes have been made in the content of Unit 1, The History and Development of the Care of the Mentally Ill. In Unit 2, chapter on Night Duty appears superfluous in view of the fact that the care of the patient is a continuous process and the same principles apply for the 24-hour period of nursing care. The nursing reports, written by students, on problems encountered in psychiatric nursing are well executed but would have more value if considered in relation to the total care of selected patients and prepared by the specialist in psychiatric nursing. The chapter on Reaction Types, in Unit 3, gives more consideration to the individual in the aging period. The nursing care is complete and well presented and would be valuable to the nurse in the hospital as well as in the community. In this same unit, the chapter on Specific Psychiatric Treatments has been brought up to date. The addition of Nursing in the Services, in Unit 4, has little to offer since modifications will be necessary depending on philosophy and facilities available. A chapter on Legal Aspects has been included and that on Mental Hygiene has been amplified to encompass present trends.

This textbook written primarily for the undergraduate student, with its bibliography covering a wide range of related subjects, would be a worthwhile addition to the nursing school library.

—Margaret Joinville, *R.N., B.S., Acting Director of Psychiatric Nursing, Cornell University, N. Y. Hospital, N. Y.*

GENERAL

U. S. A. Measure of a Nation. A graphic presentation of America's needs and resources. By Thomas R. Carskadon and Rudolf Modley. The Macmillan Company, 60 Fifth Avenue, N. Y. 1949. 101 p. $1.00.

Two Lessons of Group Dynamics. Published by Educator's Washington Dispatch, Deep River, Connecticut. 1948. 11 p. 25c each, special quantity discounts.

A discussion of some aspects of group dynamics which will be of benefit to all committee and conference workers.

Can Labor and Management Work Together? By Osgood Nichols and Thomas R. Carskadon. 32 p. Public Affairs Pamphlet No. 151. Public Affairs Committee, Inc., 22 E. 38 Street, N. Y. 1949. 20c.

Public Health and Welfare in Japan. Three volumes. General Headquarters, Supreme Commander for the Allied Powers, Public Health and Welfare Section, A.P.O. 500, San Francisco. 1949.

In addition to a review of the problems, activities and future programs of the Public Health and Welfare Section, GHQ, SCAP, there is included a summary of historical health data on Japan for the period 1900-1948.

CONSTRUCTIVE USES OF ATOMIC ENERGY. Edited by S. C. Rothmann. New York, Harper and Brothers. 1949. 258 p. $3.00.

LABORATORY MANUAL OF CHEMISTRY. By Joseph I. Routh. 2nd. ed. Philadelphia, W. B. Saunders. 1949. 98 p. $1.25.

FUNDAMENTALS OF INORGANIC, ORGANIC AND BIOLOGICAL CHEMISTRY. By Joseph I. Routh. 2nd. ed. Philadelphia, W. B. Saunders, 1949. 346 p. $3.25.

THE FAMILY IN A DEMOCRATIC SOCIETY. Anniversary Papers of the Community Service Society of N. Y. New York, Columbia University Press. 1949. 287 p. $3.75.

HEALTH CENTER BUILDINGS. By Harry E. Handley. New York, The Commonwealth Fund, 1948. 48 p. 50c.

DENTAL HEALTH

DENTAL HEALTH PROGRAM FOR ELEMENTARY AND SECONDARY SCHOOLS. American Dental Association, 222 East Superior St., Chicago 11, Illinois. 1947. 40 p.

GERIATRICS

SOCIAL ADJUSTMENT IN OLD AGE—A RESEARCH PLANNING REPORT. By Otto Pollak. New York, Social Science Research Council. Bulletin 59, 1948. 199 p.

OLD-AGE PROBLEMS IN THE FAMILY. By J. H. Sheldon. *The Milbank Memorial Fund Quarterly* April 1949, vol. 27, p. 119-132.

NURSING

MEASURING NURSING RESOURCES. Prepared by Lois E. Gordner. Federal Security Agency, Public Health Service, Washington, D.C. 1949. 117 p. Copies available on request.

Guide to a method for nurses and others who contemplate studies to determine nursing needs and resources on an area basis.

NURSING EDUCATION

CLINICAL INSTRUCTION. By Amy Frances Brown. Philadelphia, W. B. Saunders. 1949. 571 p. $5.50.

NURSING IN CLINICAL MEDICINE. By Julius Jensen and Deborah Maclurg Jensen. 3rd. ed. New York, Macmillan. 1949. 791 p. $4.00.

SELF-TEACHING TESTS IN ARITHMETIC FOR NURSES. By Ruth W. Jessee. 3rd. ed. St. Louis, C. V. Mosby, 1949. 122 p. $2.00.

GYNECOLOGY AND GYNECOLOGICAL NURSING. By Norman F. Miller and Betty Hyde. 2nd. ed. Philadelphia, W. B. Saunders. 1949. 485 p. $4.25.

THE EFFECT OF EXPERIENCE ON NURSING ACHIEVEMENT. By R. Louise McManus. New York, Bureau of Publications, Teachers College, 1949. 64 p. $2.10.

In conclusion the author finds, "The graduate nurse by continuing her professional study informally can increase her knowledge of the scientific facts and principles that should function in the nursing of her patient. If this independent study is augmented at intervals by advanced education sufficient for keeping abreast with the progress made within the profession, a much higher level of development of acuity of judgment can be expected as well as a much finer quality of professional nursing service."

CONTRACTUAL RELATIONSHIPS EXISTING BETWEEN SCHOOLS OF NURSING AND PARTICIPATING AGENCIES. By Sister Mary Alma Maguire. Washington, D. C., The Catholic University of America Press. 1949. 44 p. $1.00.

The purpose of this dissertation is to study contractual agreements now in existence in order to evolve a master contract useful as a pattern.

MATERIA MEDICA FOR NURSES. By Lois Oakes and Arnold Bennett. 3rd. ed. Baltimore, The Williams and Wilkins Co. 1949. 373 p. $3.00.

POLIOMYELITIS

WHEN YOUR CHILD HAS INFANTILE PARALYSIS—SUGGESTIONS FOR PARENTS. The National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y. 36 p. Free.

PSYCHIATRY

CHILD PSYCHIATRY. By Leo Kanner. 2nd. ed. Springfield, Illinois, Charles C. Thomas. 1949. 752 p. $8.50.

PSYCHOLOGY

PSYCHOLOGY AND THE NURSE. By Frank J. O'Hara. 3rd. ed. Philadelphia, W. B. Saunders. 1949. 253 p. $2.75.

SOCIAL PSYCHOLOGY. By Richard T. LaPiere and Paul R. Farnsworth. 3rd. ed. New York, McGraw-Hill, 1949. 626 p. $4.50.

SALARIES

SALARIES OF LOCAL PUBLIC HEALTH WORKERS. A report prepared in cooperation with the APHA and the Association of State and Territorial Health Officers. April 1949. 42 p.

SALARIES OF NURSES EMPLOYED FOR PUBLIC HEALTH WORK IN LOCAL BOARDS OF EDUCATION AND IN NONOFFICIAL AGENCIES. A report prepared in cooperation with the APHA, ASTHO, and the NOPHN. Supplement No. 1, 13 p.

A limited number of second report available from the Federal Security Agency, Public Health Service, Bureau of State Services, Washington, D.C.

FROM NOPHN HEADQUARTERS

DINNER TO MISS FOX

Signalizing 40 years in nursing service and 20 years as director of the Visiting Nurse Association of New Haven, Connecticut, a dinner was tendered Elizabeth Gordon Fox on October 19 in New Haven. A large and happy group of friends and admirers were present, including former Surgeon General Thomas Parran and Dr. Ira V. Hiscock of Yale who with Miss Fox were chief speakers; Emeline Street, president of the VNA and Dorothy Wilson, new executive director; Ruth Hubbard, president, and Anna Fillmore, general director, of NOPHN; Dr. and Mrs. C.-E. A. Winslow, Annie W. Goodrich, Effie Taylor and many others.

Miss Fox graduated with academic honors from the University of Wisconsin in 1907, then enrolled for three years of nursing at Johns Hopkins Hospital followed by postgraduate work in the same institution. She served as superintendent of the Dayton (Ohio) VNA, 1913-1915, and of the Washington (D.C.) VNS, 1915-1918. From 1918-1929 Miss Fox was national director of the Public Health Nursing Service of the American Red Cross. Under her leadership rural public health nursing service grew from a small service in a few communities to some 2,000 nurses in about 40 percent of the counties in the United States.

Miss Fox was president of NOPHN from 1921 to 1926 and subsequently gave important service on many NOPHN committees.

As director of the VNA of New Haven, Miss Fox built a service distinguished for quality as well as for courage in pioneering.

Dr. Winslow said (in the *New Haven Register*), referring to the dinner in her honor, "Such a gathering must stress the debt our city owes Miss Fox. She has made our Visiting Nurse Association stand out before all associations. Fewer than can be counted on the fingers of one hand rank with ours. The credit belongs first to Director Elizabeth Fox, her staff, and to the board of lay people who have unselfishly and unstintingly supported her in providing what she needed. There has been teamwork throughout."

MISS SHEAHAN HONORED

Marion Sheahan, public health nurse, is the winner of the 1949 Lasker Award of the American Public Health Association. Miss Sheahan who is now the director of programs of the National Committee for Improvement of Nursing Services has had a long and distinguished career in nursing. A graduate of St. Peter's Hospital in Albany, New York, she volunteered her services to the Infant Welfare Station in Albany, then went to Henry Street Settlement for training and experience in public health nursing. Later she became county tuberculosis nurse and family health counselor for Niagara County, then tuberculosis supervisor for the State Department of Health. She became assistant director of the Division of Public Health Nursing, and director from 1932 to 1948. She has lectured and taught at Teachers College, Columbia, and at the Universities of California and Minnesota.

Miss Sheahan was president of NOPHN from 1944 to 1946. Over a long period of years, moreover, she played an important part in many of the National Organization's larger undertakings, acting as promoter, sponsor, and guide.

The Lasker Award, consisting of $1,000 and a gold replica of the Winged Victory of Samothrace to symbolize victory over death and disease, was presented October 25 at the annual meeting of the APHA. Her citation read:

"For her inspiring leadership, skills, and unswerving devotion to 'her visions of a better world'. . . . Her creative thinking helped to mold plans which enabled nursing to play its proper role throughout World War II in health protection on the home front and mobilization of nursing personnel for the Armed Services. Her comprehensive program for

nationwide action in the field of nursing became the blueprint which initiated and will guide progress in nursing for many years to come. As Director of Public Health Nursing in New York she pioneered new methods that set the pattern for her own and many other states.

"With ability and courage to reach difficult goals Miss Sheahan has forged a record of superb achievement by her accomplishments."

COUNCIL ON TB NURSING MEETS

The Council on Tuberculosis Nursing met in New York City, October 6, to review the accomplishments of the Joint Tuberculosis Nursing Advisory Service, a joint project of NOPHN and NLNE under a special grant from the National Tuberculosis Association. Program and budget of JTNAS for 1950 were considered. Katharine Amberson, secretary of the Council, reported that as of October 1, some 14,250 copies of "Safer Ways in Nursing to Protect Against Tuberculosis" had been distributed through state and local tuberculosis associations. The Pan American Sanitary Bureau is translating the guide into Spanish and permission for a Japanese translation has recently been granted to the Nursing Division of the Public Health and Welfare Section, General Headquarters, Supreme Commander for the Allied Powers. Jean South, public health nursing tuberculosis consultant of JTNAS, reported that an opportunity would be given, at the NTA annual meeting in Washington, next April, for a special meeting of public health nursing tuberculosis consultants to discuss programs and mutual problems. According to the latest count of the Public Health Service there are, in 35 states, Alaska, Hawaii, and Puerto Rico, 59 nurse consultants employed by public health agencies in tuberculosis control.

NEW JOINT PUBLICATIONS

"Instructional Plan for Basic Tuberculosis Nursing" (58-page pamphlet) is now available. This was prepared by the subcommittee on tuberculosis nursing of the Committee on Curriculum co-sponsored by the Joint Tuberculosis Nursing Advisory Service of NLNE, NOPHN, and NTA. Copies are $1 each.

A bibliography of articles on psychiatric nursing and mental hygiene in four sections—general, nursing service, nursing education, and community aspects of mental health (largely from PHN and *AJN*) is now available from the National League of Nursing Education. The price is 75 cents.

Also available from NLNE is the 54-page mimeographed pamphlet "Descriptive Criteria for Evaluation of Advanced Programs of Study in Psychiatric Nursing and Mental Hygiene" (75 cents). This material emerged from the one-and-a-half-year study conducted under the auspices of NOPHN and the League. It will be extremely useful to those contemplating the establishment of advanced programs in psychiatric nursing and mental hygiene as well as to those connected with already established programs, many of whom participated in the study.

PHN TO BE MICROFILMED

A pressing problem facing libraries today is that of providing adequate space for the constant flow of publications. NOPHN has entered into an agreement with University Microfilms, Ann Arbor, Michigan, to make available to libraries the magazine PUBLIC HEALTH NURSING in microfilm form. The entire volume can be placed on a single roll at a price between ¼ and ⅕ cents a page. Under the plan the library keeps the printed issues unbound and circulates them for from two to three years which corresponds to the period of greatest use. When paper copies begin to wear out or are not called for frequently they are discarded and the microfilm substituted. Sales are restricted to subscribers to the regular issues, and film copy is distributed at the end of the volume year.

Inquiries regarding purchase may be directed to University Microfilms, 313 North First Street, Ann Arbor, Michigan.

JONAS STAFF CHANGES

Miriam Crouch (A.B., Marietta College, M.S., Boston University; M.N., Frances Payne Bolton School of Nursing, Western Reserve) has accepted a one-year appointment on the staff of the Joint Orthopedic Nursing Advisory Service as orthopedic nursing consultant for NLNE. For the past two

years Miss Crouch has been supervisor of surgical and orthopedic nursing at Harborview, Seattle, Washington, with faculty appointment with the University of Washington School of Nursing. She is now on leave of absence from this position. In 1946 Miss Crouch was awarded a scholarship by the National Foundation for Infantile Paralysis for advanced study in orthopedic nursing at Boston University.

Lois Olmsted (Cook County, Chicago; M. S., Western Reserve), who has been consultant for NLNE on the JONAS staff since 1944, resigned in October. She is succeeded as senior consultant for NLNE by Teresa Fallon (Lowell, Mass., General; B.S., Boston University), who has been on the JONAS staff since early this year.

Louise M. Suchomel (Children's, Detroit: B.S. Wayne University), who has been consultant for NOPHN since 1945 is now administrative head of the service.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Anna Fillmore	Reading, Pa.—Nov. 5
Hedwig Cohen	Lynn, Mass.—Oct. 31-Nov. 5
	Everett, Mass.—Nov. 7
	Concord, Mass.—Nov. 8
	Gardner, Mass.—Nov. 9
	Princeton, N. J.—Nov. 29, 30
M. Olwen Davies	Newark, N. J.—Nov. 1
	Cleveland, Ohio—Nov. 9, 10
	Cincinnati, Ohio—Nov. 28-30
Ruth Fisher	Princeton, N. J.—Nov. 29, 30
Marion P. Kerr	Rochester, N. Y.—Nov. 14-19
Dorothy Rusby	Omaha, Neb.—Nov. 7-18
	Seattle, Wash.—Nov. 21-Dec. 2
Jean South	Dayton, Ohio—Nov. 17, 18
Louise M. Suchomel	Washington, D. C.—Nov. 10
	Rochester, N. Y.—Nov. 14-19
	Des Moines, Iowa—Nov. 21-23
Marie Swanson	Washington, D. C.—Nov. 5, 6

Field trips not previously announced included a visit to Syracuse, N. Y., in September by Ruth Fisher, and to Boston, Mass., in October, by Jean South.

ABOUT PEOPLE YOU KNOW

Marie M. Knowles, for 10 years executive director of the VNA of Brooklyn, has resigned to return to her native state of Maine. She will be succeeded on January 1 by Eleanor W. Mole. Miss Knowles has always had as a first concern the improvement of service to the community and has made notable progress during her period of office in deepening the contribution of the VNA of Brooklyn to the people it serves. She has been a member of NOPHN Committee on Nursing Administration. Since 1940 Miss Mole has served as assistant director of the VNA. For two years she has directed the joint educational program of the VNSNY and the VNA of Brooklyn. She has been a member of the NOPHN Education Committee and the Committee (NLNE and NOPHN) on the Integration of the Social and Health Aspects of Nursing in the Basic Curriculum.

Mary M. Roberts, formerly editor-in-chief of the *American Journal of Nursing*, has been elected to Honorary Fellowship in the American College of Hospital Administrators.

Mrs. Gladys N. Dundore, executive secretary of the AAIN, on October 21 was presented with the 1949 Pennsylvania Ambassador Award, the first time the Commonwealth of Pennsylvania has so honored a public health and industrial nurse. She was one of 26 sons and daughters of Pennsylvania chosen by the State Chamber of Commerce as having achieved merited success in other states or abroad. Clarissa Gibson, director of the VNA of Scranton and Lackawanna County, represented NOPHN at the presentation ceremony.

Elizabeth C. Gauscheman has recently been appointed chief of the nursing unit at the VA regional office, Huntington, West Virginia. . . . Appointment of Nancy L. Haney, formerly associate editor of the Publications Department of the YWCA, National Board, as assistant to the public relations director of the Committee on Careers in Nursing has been announced. . . . Lydia Reitz is new assistant professor of Public Health Nursing at the University of Buffalo. . . . Catherine B. Glennon began work October 1 as field coordinator, Division of Nursing Education, Indiana University. . . . Mrs. Esther B. Bartlett was appointed superintendent of the Bureau of Public Health Nursing, Toledo, Ohio, October 1.

NEWS AND VIEWS

SECOND MENTAL HEALTH ASSEMBLY

The Second Mental Health Assembly of World Federation for Mental Health met in Geneva, Switzerland, August 22-27, at which time it completed plans for its activities during the coming year. Dr. J. R. Rees (England) was appointed director-general, and Dr. Kenneth Soddy (England) secretary. The offices of the Federation will continue to be located temporarily at 19 Manchester Street, London W 1, England.

All member associations throughout the world were invited to send delegates and observers. Several hundred attended, among them a delegation of at least forty from the U. S. A. Ruth Taylor was NOPHN's representative, and Elizabeth Brackett acted as observer.

The World Federation for Mental Health was granted consultative status to World Health Organization and to UNESCO at the close of the International Congress on Mental Health in London in 1948. It thus set up a two-way traffic with governments. Not only can it pass on the results of modern studies to appropriate government departments but it is being informed of topics which governments would like investigated, and distributing these to appropriate research groups and universities.

The report of the International Preparatory Commission, prepared last year from studies made by societies and discussion groups in the various countries sending delegates to the conference, embodied important recommendations on the prevention of mental illness, and WHO has incorporated most of these in its program. The International Preparatory Commission, of which Lawrence K. Frank was chairman, proposed a preliminary study of the methods used in various countries for dealing with mental ill health and maintaining mental health. Member associations of the Federation have already begun this work and it is thought that UNESCO may gather more data in the course of their studies of comparative cultures. An estimate of existing social agencies for the care of the mentally ill was also proposed, and a survey of the incidence of mental ill health in its broadest sense will probably be undertaken. A highly practical proposal was that teachers should be sent to train workers on the spot in backward countries and areas. Students brought from such areas to study in advanced and well equipped countries and then sent back to battle with primitive conditions, are apt to despair and give up the struggle

The World Federation for Mental Health has made a useful and important start. Its difficulties are largely financial. To maintain an office and secretariat at Geneva, and to bring the executive committee from the ends of the earth twice yearly calls for an annual income of $120,000. Several contributors have given initial financial support and it is hoped that other funds will be forthcoming. It is impossible to lay down or extend policy until the income of the Federation is known.

RED CROSS RECOMMENDS ACCELERATED NURSING PROGRAMS

Based on exhaustive study of nursing needs and resources, the Board of Governors of the American National Red Cross has recommended an accelerated program of nursing services for the organization designed to better meet community requests in the fields of home nursing and nurse's aide instruction, disaster nursing, and the overall enrollment of nurses for volunteer service in the community.

This recent action recommends instructor training courses for all home nursing instructors; intensive training of qualified nurses for potential disaster duty; teaching of nurse's aide classes to meet needs of both public and private health agancies as well as hospitals; and increasing efforts toward enrollment of nurses to carry on these programs.

To implement these recommendations steps already have been taken to increase the number of nurses qualified as instructor-trainers for home nursing. They will be responsible for training and supervising of instructors in their local communities.

This plan, coupled with the new policy of utilizing carefully selected and trained non-nurses as instructors in the basic course, will mean not only that knowledge of simple home care of the sick soon will reach far more Americans, but also that the need for nurses to train and supervise these non-nurses will increase, so that a challenge exists for all nurses who are anxious to contribute to community service "beyond the line of duty."

As further impetus to augmented classes, home nursing instruction now will be concentrated in two courses instead of the five previous courses, and greater emphasis will be placed on reaching ready-made institutional groups: schools, military camps, industrial workers and their families, civic organizations, and housing projects. Meanwhile, opportunity for home nursing instruction in each community will continue.

NURSES CALLED TO SERVE ON INDIAN HOSPITALS

To meet immediate needs of hospitals on Indian reservations in several western states, the American Red Cross in October launched a campaign to recruit some 50 qualified nurses for three months' emergency duty with the Bureau of Indian Affairs.

In announcing the participation of Red Cross in the recruitment, Ruth B. Freeman, national administrator of Nursing Services, stressed the grave situation. Sick patients actually have been refused admission to some of the hospitals because lack of nurses has made it necessary to close entire wards, she said. On one reservation the hospital, only one within a hundred miles, has been closed and in others hospital wards and beds are not being utilized because of lack of staff.

Most immediate needs are on Indian reservations in Arizona, Utah, and the Dakotas, where the severe storms of the past winter have accentuated the already severe health problems, she pointed out.

Nursing with the Indian Service presents a challenge to those nurses who seek adventure in fighting disease and contributing to the health and well-being of these native Americans, she said. The reservations are often remote from urban advantages but offer interesting, unique work and scenic attraction.

NACGN-ANA LIAISON COMMITTEE FORMED

Designation of the Board of Directors of the National Association of Colored Graduate Nurses as members of a liaison committee, which will also include representatives of the American Nurses Association and will seek to facilitate integration of the programs of the two organizations, was announced September 21 by Mrs. Mabel K. Staupers, R.N., president of NACGN.

The launching of this committee was viewed by Mrs. Staupers as the first step in the recently adopted program of NACGN to work even more closely with ANA toward fullest integration of Negro nurses into the broad national fields of professional nursing.

She cited a report of a special ANA committee which, after a study of the functions of NACGN as they related to those of ANA, had recommended certain positive steps in this direction. These recommendations, which were approved by the ANA Board in August included provision by ANA of an office and field service with sufficient personnel, and educational materials, to stimulate effective participation by Negro nurses in the total program of ANA. It was further recommended that these services be made available without segregation either in staff assignments or in opportunities for membership participation in programs and projects of ANA.

The ANA committee report, presented to the recent NACGN convention in Louisville, Kentucky, for consideration, was approved unanimously, Mrs. Staupers said, and the setting up of the liaison committee was also one of the recommendations.

Questioned about recent reports that the NACGN was contemplating dissolution in the near future, Mrs. Staupers characterized such rumors as "without foundation."

"GIVE ENOUGH FOR THE USO"

The United Service Organization by public demand has been reactivated as a link between our military personnel and the civilian public. The maintenance of morale is especially important in the peacetime military establishment. In 1948, the armed forces inducted 700,000 men and women into service, 500,000 of whom were under 21. This fact alone emphasizes the vast social impact on youth of our national defense program.

Uso is organizing state committees to conduct this year's campaign for 1950 funds. The Community Chest will be an important aid in many localities in achieving the goal visualized. The National Budget Committee has approved a 1950 budget for Uso of $12,100,000, of which $10,100,000 will be assigned to state and local community quotas. Provisions will be made for raising the remaining $2,000,000.

PROFESSIONAL REGISTERED NURSE INVENTORY

A complete inventory of registered professional nurses in the USA and its territories has been released by the American Nurses' Association at the request of the National Security Resources Board. The inventory which has been secured through cooperation with state nurse-licensing boards and state nurses' associations, provides data on the number and location, age, marital status, responsibility for dependents, whether the nurse is actively engaged in nursing and the field of employment and position, type of preparation and experience in special fields.

On the basis of a total of 633,223 questionnaires mailed and the usable returns after duplications were weeded out due to many nurses being currently registered in more than one state, it was established that there are a total of 506,050 professional registered nurses, active and inactive. Of the 300,533 active group, 141,882 are in hospital and other institutions; 7,839 in school of nursing, 4,044 in hospital and school of nursing; 28,930 in public health; 272, public health and school of nursing; 65,032, private duty; 13,113, industrial; 26,444, office; other and unclassified, 12,978.

"Maintaining the census of nurses on a current basis will become a permanent routine procedure and will enable professional nurses to initiate more effectively measures for increasing nursing strength to meet all needs," said Pearl McIver, president of ANA.

Paper bound copies are available from the ANA at 1790 Broadway, at $1 per copy.

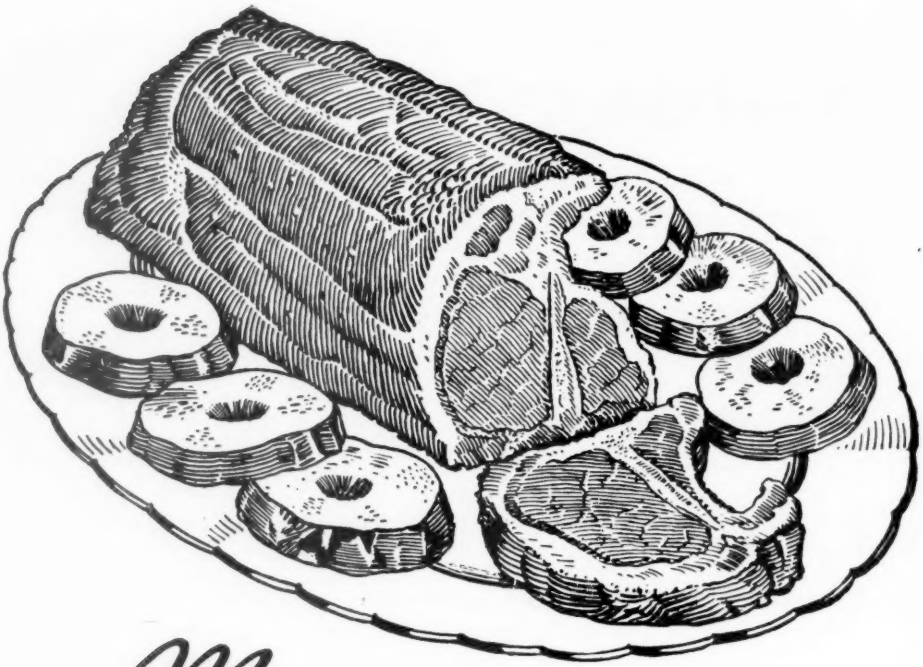
TEACHING ABOUT POLIOMYELITIS

Anatomical drawings relating to infantile paralysis are now available to nursing schools or to centers handling postgraduate nursing education. These were drawn by Dr. Frank H. Netter and originally appeared in the August 15, 1949 issue of *Life*. Requests may be made to Education Service, National Foundation for Infantile Paralysis, 120 Broadway, New York 5, New York.

● A six day institute on Clinical Aspects of Heart Disease was held in Cincinnati, Ohio, September 12-17, for public health nurse supervisors and public health agency directors throughout Ohio. The institute was sponsored by the Ohio Department of Health and the College of Nursing and Health, University of Cincinnati. Other agencies assisting with the program were Cincinnati and Hamilton County Health Department, Heart Council of the Public Health Federation, College of Medicine, University of Cincinnati, Children's Hospital, Children's Convalescent Home, Condon School, and Cincinnati General Hospital. Dean Laura Rosnagle as chairman of the Planning Committee and Minnie Bohlman, assistant professor of nursing and health, as coordinator of the program, were in charge of the meetings.

The program included nursing care and the newer developments in treating such conditions as rheumatic fever, congenital heart disease, subacute bacterial endocarditis, hypertension, and congestive heart failure. Special emphasis was placed upon the preventive aspects of cardiac disease and on the opportunities of the public health nurse to teach the cardiac patient how to be a useful citizen in spite of his handicap.

● "Achieving Goals for the Handicapped" will be the theme of the annual convention of the National Society for Crippled Children and Adults to be held November 7-10 at the Hotel Commodore in New York.



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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (Apr. 2,) 1949

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Now you can have those well-groomed hands *On Duty* as well as *Off Duty*—in spite of the drying damage of frequent scrubbings, soap and water.

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For TRUSHAY does double duty with its unique "beforehand" extra. Smoothed on *before* frequent washings, TRUSHAY protects your hands even in hot, soapy water—guards the skin by helping to preserve its natural lubricants.

Begin today to use TRUSHAY *—and when patients admire your well-groomed hands, tell them about the lotion with the "beforehand" extra,* TRUSHAY.

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You know, you do more for your patient than you might think . . . .

For instance, your crisp clean uniform and your air of confident grooming go a long way to brighten your patient's day.

But good grooming is more than the morning bath and a bright fresh uniform. Because perspiration is a continuous process.

MUM is the safer way to preserve morning bath freshness. You'll love its delightful new floral odor, its creamy texture. And MUM is sure because it prevents underarm odor throughout the day or evening. Recommend it to your patients too.

Why take a chance when you can MUM in a moment?

Safer for charm . . .
Safer for skin . . .
Safer for clothes . . .

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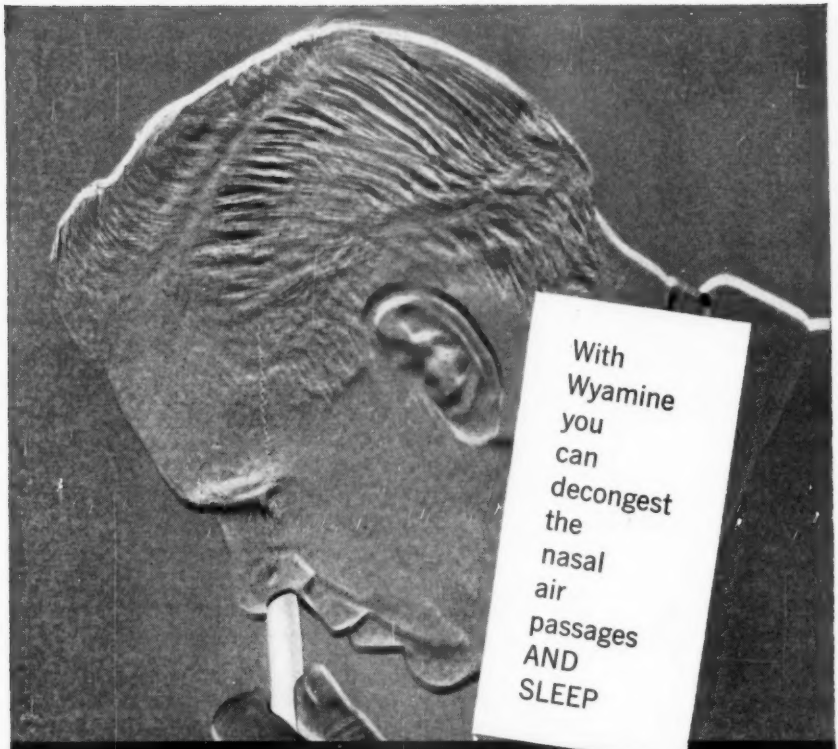

WYAMINE

Mephentermine* Wyeth

Safe to use even at night

**N-methylphenyl-tertiary butylamine*

WYAMINE, either as the volatile base or the water-soluble sulfate, is an effective new vasoconstrictor, possessing several important advantages. It produces a local vasoconstriction approximately equal to that of ephedrine, but its action is very rarely attended by returgescence, or by nervousness, excitability or insomnia.

Four Convenient Dosage Forms:

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WYAMINE-PENICILLIN CAPSULES *for Preparation of Nasal Solution*

SOLUTION WYAMINE SULFATE

SOLUTION WYAMINE-TYROTHRICIN

Use with dropper or **JETOMIZER®**

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Report Your New Address

Please report change of address direct to PUBLIC HEALTH NURSING, allowing 6 weeks before change is to take effect. (Be sure to send your old address together with the new address.) Copies that *have been mailed* to an old address will not be forwarded by the Post Office unless extra postage is sent to the Post Office by the subscriber. Avoid such expense, and make sure of getting your copies promptly, by notifying PHN in advance.

NUCOA does DOUBLE DUTY!

You'll serve it proudly on your table!

Money can't buy a better spread than Nucoa as far as smooth texture and fresh delicate flavor are concerned. Or as far as *nutrition* is concerned. No other *churned spread*—at any price—is richer in food energy or a finer year-round source of vitamin A. And Nucoa colors to such a tempting *even* yellow! (Incidentally, the new **MEASURE-PAK** Nucoa "bowl-mixes" more easily than ever.)

You'll love it in the kitchen, too!

It's a real luxury to use delicious, wholesome Nucoa margarine for cakes, cookies, pastries . . . and a luxury you can afford. And now Nucoa is so wonderfully *convenient* to cook with because every pound is cut in quarters—makes measuring so much *easier*. Just follow the handy measuring guide below and forget messy spoon-and-cup measuring.

NUCOA—America's Favorite Margarine

POSITIONS AVAILABLE

WANTED—One public health nursing supervisor for staff of 10 nurses in generalized program in city health department. Salary range—$278 to $333. Three staff nurses—salary range—$266 to $319. Write: Public Health Nursing Division, City Health Department, Room 200, City Hall, Sacramento, California.

WANTED—Assistant Director for a private visiting nurse and tuberculosis association. Qualifications: a degree and at least one year of supervisory experience in a private organization. Salary based on qualifications and experience. Staff of 6 nurses, 2 student nurses, a non-nurse health education worker, a part time x-ray team. Retirement plan, five-day week, liberal vacation and sick leave. Opportunity for advancement. Write: Visiting Nurse and Tuberculosis Association, 115 East Church Street, Elmira, N. Y.

WANTED—Two staff nurses for generalized program in a combined agency, health department and bedside nursing functions. Maternal and child health supervision, communicable disease, tuberculosis and parochial school nursing. Student affiliation with University of Texas School of Nursing. Salary $2,640 annually. One year public health nursing course preferred. Forty hour week; one month vacation; sick leave; no car required. Write: Director, Galveston Public Health Nursing Service, 4127 Avenue I, Galveston, Texas.

WANTED—Public health nurses for a number of County Health Departments in Oregon. Salary $240 to $300 per month to start. Some counties furnish transportation. Merit status, vacation and sick leave, retirement. Write: Oregon State Board of Health, 1022 S. W. Eleventh Avenue, Portland 5, Oregon.

WANTED—A staff public health nurse as soon as she is available for work in a large university town. Salary range now $220 to $265 per month. Automatic salary increases; cost-of-living salary adjustments semi-annually; adequate mileage allowance; statewide retirement program. Applications will be accepted until the needs of the service are filled. Write: Personnel Division, City Hall, Madison 3, Wisconsin.

WANTED—Two staff nurses for our generalized bedside and health supervision visiting nursing program. All holidays, one month's vacation, 2 weeks' sick leave. Mileage 10c; car desirable but not essential. Salary open. Write: Julia M. Williams, Supervisor Public Health Nursing Service, Brattleboro Mutual Aid Association, Brattleboro, Vermont.

WANTED—Public health nurses for city-county health department. Excellent opportunities for growth in a generalized program under qualified supervision. Near state university and colleges offering extension courses. Approved field training area for post-graduate and graduate students. For particulars write: Medical Director, Calhoun County Health Department, City Hall, Battle Creek, Michigan.

WANTED—Qualified public health nurses having, or eligible for, California registration and certificate in Public Health Nursing. Must own and drive car and be willing to live in city. Generalized public health program. City of 100,000. Salary $265-$311. Send full particulars and recent photograph to City Manager, Richmond, California.

WANTED—Three qualified public health staff nurses. Starting salary $2,921.50. Car furnished or allowance; 5 day week. Inservice training. Newly revised generalized program. Opportunity to work under highly qualified supervision. Write: Chairman, Board of Health, City Hall, La Crosse, Wisconsin.

WANTED—Two public health nurses for staff position in generalized public health program. County of 14,000 population, ideal climate. One month's vacation; retirement plan; car furnished or 7c milage on own car; salary $3,480. Must have certificate and one year's experience in public health nursing. Apply: Roswell L. Hull, Health Officer, San Benito County, Hollister, California.

WANTED—Qualified public health nurses for visiting nurse program. Salary $245 to $275 for nurses with certificate. Liberal car allowance for personal car which is mandatory. Also director wanted for nursing service. Write: Sacramento Chapter, American Red Cross, 1300 G Street, Sacramento 14, Calif.

"Wait, John Alden...something is missing!"

The little modern "Priscilla," casting a practiced eye over the food gathered for the Thanksgiving feast, was appalled to note that the meal was not complete. For example, she could not see any bread, flour or cereal, one of the basic 7 food groups needed in daily diets.

A page from American history? Well, not strictly speaking. This classroom skit was more than an attempt to dramatize history; it was also a project in nutrition. With foods prepared for them in the school lunchroom, the children were using the framework of the Thanksgiving story to point up an important lesson in eating habits. The vital study of nutrition was being integrated with other important classroom subjects. The teacher did not need to allot special time for it.

Suggestions for incorporating a Thanksgiving theme and nutrition project into regular classroom studies are at the right. Use them as starting points for ideas of your own. For further assistance in introducing and maintaining nutrition study, take advantage of General Mills "Program of Assistance in Nutrition and Health Education." Plans, ideas and materials—adaptable to any curriculum—are available through the program. For further information write Education Section, Dept. of Public Services, General Mills, Inc., Minneapolis 1, Minn.

SUGGESTED STUDY

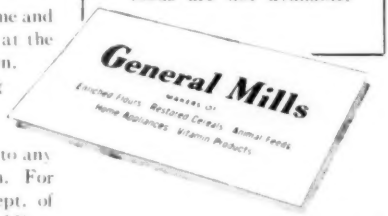
Reading: Stories about the Plymouth Colony

History: First Thanksgiving Customs of the Pilgrims
1. How they dressed
2. What they ate

Social Sciences: Colony Cooperation Relations with Indians

Arithmetic: Amounts of various foods necessary for a Thanksgiving Dinner

Art: Props and costumes for skit; cut-outs of Thanksgiving food when actual foods are not available.



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NOPHN Style 485 is a magnificent "lifetime" coat. Made of Navy Blue All Wool Elastique outer material and mothproofed by Bocanize Process. Fully lined with Skinner's satin-faced wool-back lining. Convertible collar. Complete All Wool Flannel detachable zip-in lining with famous Talon zipper. Sizes 32-46.

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